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THE INSURANCE INDUSTRY AND ACCESS TO HEALTH CARE AND LONG-TERM CARE

HEARING

BEFORE

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION
ON
COMPREHENSIVE HEALTH CARE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

DES MOINES, IA

AUGUST 21, 1989

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THE INSURANCE INDUSTRY AND ACCESS TO HEALTH CARE AND LONG-TERM CARE

MONDAY, AUGUST 21, 1989

THE PEPPER COMMISSION
U.S. BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE
Des Moines, IA.

The Commission met, pursuant to notice, at 8:30 a.m., at the Convention Center, Des Moines, IA, Hon. Tom Tauke (Representative of the Commission), presiding.

Present: Representative Tom Tauke.

Also Present: Edward F. Howard, general counsel; Monica E. McFadden, Philip Shandler, and Joy Johnson Wilson, professional staff.

OPENING STATEMENT OF CHAIRMAN TOM TAUKE

Chairman TAUKE. Good morning, ladies and gentlemen, and welcome to this field hearing of the U.S. Commission on Comprehensive Health Care, known as the Pepper Commission. The Commission was created by Congress in 1988 to develop recommendations for closing the gaps in our Nation's health care system, and there is no doubt that we do have substantial gaps in our Nation's health care system at the current time.

We have 31 to 37 million Americans who have no health insurance at all. We have an equal number of individuals in the Nation who have inadequate health care insurance coverage. And the need for long-term care for the elderly and for many citizens who have disabilities is obviously acute.

The Commission's report to Congress is due in March and will play an important role in the debate in Congress over the future of the Nation's health care system.

When our Commission was first formed, Claude Pepper, the former Congressman from Florida, was elected as chair. Of course, as many of you know, Claude Pepper, a champion of the causes of the elderly in the Nation, passed away earlier this year. But we hope that this Commission will serve as a legacy for him in his outstanding work in Congress, particularly on the issue of health care.

Today's hearing here in Iowa is one of a series of hearings that members of the Commission are hosting across the Nation. Iowa has much to share with the Nation and with Congress as we strive to ensure that all of our citizens have access to health care coverage.

First, Iowa has one of the highest percentages of the elderly as part of the total State population and the highest percentage of those 85 and older of any State in the Nation. We in Iowa are experiencing now what the rest of the Nation will soon be experiencing: an increasingly elderly population with greater need for health care services and particularly for long-term home and nursing home care.

Second, a young Iowa child, Katie Beckett, was the first child to receive Medicaid home health care coverage under a new Medicaid Waiver Program, and Iowa is in the forefront of developing high-quality systems of family and community-based care for its medically fragile children. Today, many children across the Nation are receiving care at home with their families who otherwise would be institutionalized, but many more children remain institutionalized who could be at home if the appropriate supports were available to their families—where, in other words, if we made a proper change in Federal and State policies. And many families who are caring for children or elderly persons at home face sometimes overwhelming unmet needs.

Third, Iowa is the second largest insurance center in the Nation, making us an ideal place to examine the role of insurance in addressing the problems of those without any coverage, of those with coverage which fails to meet their needs, and of coverage for long-term care.

Fourth, family farms and small businesses are the backbone of Iowa's economy, making our State an ideal place to explore the problems of self-insured persons and small businesses, the problems they have in obtaining and maintaining health insurance.

At today's hearing, we will receive testimony from noted experts and leaders in health policy and the insurance field and also from individuals and families about their needs. Their stories will, I am sure, put a compelling human face on the need for fundamental reforms in our health care system.

I want to take this opportunity to thank all of our witnesses and to thank the many organizations and individuals in our State who have helped to organize this hearing. I know that many persons in today's audience also have compelling experiences to relate to the Commission and expertise to offer, and I encourage any of you who wish to, to submit written testimony for the hearing record. We will hold the hearing record open for several weeks to receive your testimony.

As a Nation, I believe that we should be committed to the right of every individual to high-quality, basic health care services. We should have universal access to health care services.

Today's hearing will help the Commission see both the barriers to the ideal of universal access to care and the ways in which we might overcome those barriers. We come here today to seek that elusive balance among cost, quality, and access which we must find if we are to achieve our ideal of universal access to health care for all Americans.

Before beginning this morning, I would like to introduce Ed Howard, who is the general counsel for the Pepper Commission, and I was going to introduce Monica McFadden but I don't see her.

We have several other staff members from the Commission here as well whom you may see moving in and out as the day goes on and I just want to tell you that the Commission is blessed with having a very excellent staff doing outstanding work in helping the six members of the House of Representatives, the six members of the Senate, and the three Presidential appointees who make up the Commission.

Our first two witnesses today are already at the witness table. I think one of them, at least, is probably very familiar to all of you, and that is our former Governor, Bob Ray.

Bob Ray not only has developed an outstanding record as chief executive of this State, but he has also continued to devote his many talents to public service needs since he has left the office of Governor. And one of the areas in which he has performed great work is as head of the National Leadership Commission on Health Care which recently completed a report which it has submitted to Congress and is distributing to groups all across the Nation in its attempt to develop some public support behind policy changes in our health care delivery system.

I think that there has been no other group that has done as much in the analysis of the health care problems facing the Nation than the commission headed by Bob Ray. And so, Governor Ray, it's great to have you here this morning and welcome.

STATEMENT OF BOB RAY, FORMER GOVERNOR OF IOWA, AND COCHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

Governor RAY. Thank you very much.

Let me say, first of all, I have been so impressed with Congressman Tauke in his efforts to help the people of this country with the health care problems that they face, especially in rural America and the elderly and I think all of us in Iowa can feel very proud that Tom Tauke is one of those members of the Pepper Commission and, of course, we're always pleased when a Congressman will have a hearing right here in the heartland of America. So, I want to thank you for that, Tom Tauke.

I have been asked to visit with you this morning about the National Leadership Commission on Health Care and its final report. This was not a government commission and it certainly was not an ordinary one. It did have an inordinate mission—a mission to propose to the American citizenry, and especially its leaders, a comprehensive plan to stem and reverse the growing and alarming condition of health care delivery in this country.

I know I cannot do justice to this 2½-year effort in just 10 minutes, but I do sincerely thank you for the opportunity to express to you some of the findings and recommendations of the commission.

The National Leadership Commission on Health Care was created in 1986 by an outstanding and diverse group of leaders from, and interested in, all areas of health care.

Physicians and representatives of hospitals with international reputations, economists and labor leaders, leading scientists and medical researchers, top executives from some of America's leading

companies, and some of our country's greatest scholars from our top universities and medical schools.

Former Congressman Paul Rogers with 24 years experience in Congress, from Florida, cochaired the commission with me. Its honorary cochairpersons were former Presidents Jimmy Carter, Jerry Ford, and Dick Nixon. Dr. Henry Simmons was the president of the commission.

So, indeed it was a prestigious group.

While the members didn't always agree on the details, we did agree on the nature of the problem and the vision which we developed for addressing the health care problem.

That vision was for a healthy American society. A society that promotes good preventive care and healthy lifestyles through public education. A society that operates an innovative, efficient system that provides health care properly and effectively. A society where all Americans have access to health care and, therefore, health insurance. A society that encourages a sense of personal responsibility for one's own health care, and preserves a strong doctor/patient relationship. A society that promotes a partnership between government and private enterprise to improve the quality of care.

Now, the commission, in its findings and conclusions, designed a proposal which meets the criteria of this vision. It quickly determined that without addressing the question of access for every American, how to control escalating costs and at the same time assure quality and appropriateness of care, we could not succeed in arriving at a solution to today's health care dilemma.

We recognized how interwoven these three issues are and, therefore, to deal with any one of them without addressing all, would only exacerbate the problem. We had to address all of them and we had to find a systemic solution.

The first problem is the rapid and massive escalation of costs. Despite 15 years of cost-containment efforts by government and the private sector, costs have quadrupled in that same period of time, with trends, present trends, we will double the cost in just 6 more years. Costs are soaring without any apparent limit on how high they might go.

In the last 20 years, our country's health care bill, as Congressman Tauke said, has gone from 5.7 percent of the gross national product to 11 percent. We are spending $1½ billion a day on health care. In just 2 days, we spend more on health care in this country than our annual State budget in Iowa.

The second problem is diminishing access for millions of Americans. One out of four individuals in this country is either uninsured or underinsured; 11 million of the 37 million Americans who are uninsured are children.

The third issue relates to serious problems in the quality and appropriateness of much of the medical care being rendered.

The uncertainty which pervades current clinical practice is far greater than most people realize, certainly greater than I realize.

The editor of the New England Journal of Medicine estimated to the commission that at least 20 to 30 percent, and he indicated more like 30 percent, of all things done by well-meaning physicians

in good hospitals, are either inappropriate, ineffective, or unnecessary—30 percent equals a cost of $150 billion.

Regional variations of practice illustrate a wide range of the number of procedures performed differently in parts of the country and even within communities of close proximity and similar demographics. This, the commission believes, is a reflection of the absence of basic research on the outcomes of health care services and procedures and the lack of general guidelines for medical practice.

The commission became convinced that it is imperative to develop a comprehensive solution to these interconnected problems and is now presenting its consensus position to you, Congressman Tauke, and your colleagues who are political leaders of this country and to leaders of medicine, business, labor, and the consumers.

The commission's posture was always bipartisan and its approach was to work in a no-fault environment, refusing to point a finger of blame.

The framework for change, the commission believed, should be a shared responsibility between individuals and their employers on the one hand and between government and the private sector on the other hand. The health care system is a major part of the national economy and everyone shares in its problems and should also share in its solutions.

The key to the commission's plan is that individuals would take greater responsibility for obtaining, paying for, and understanding their own health care and, incidentally, changing their own health styles.

Under this plan, individuals would shoulder the primary responsibility for having health insurance, either through their employers, their own purchase, or what we call the universal access plan, or by the acronym the UNAC. People would have a choice, but if they can afford to provide coverage for themselves, no longer would they be able to freeload on others. Keep in mind that two-thirds of the uninsured are either working or are in families where there is someone working. Medicaid would be folded into the UNAC program's State pools. Older Americans would continue to receive Medicare coverage.

Since the American tradition is providing health insurance through the workplace, most Americans would continue to receive privately financed coverage as an employment benefit. So the system that dominates the health care field today would continue to do so.

The change would come in providing health insurance coverage through UNAC to everyone who has no, or inadequate coverage today. The commission refused to sidestep the tough decision of how to finance its proposal. While there are other methods for funding, such as general revenues, which many favor, the commission said that moneys for this solid, basic benefits program would be collected nationally, thus spreading the cost across the vast majority of Americans who can afford to contribute a small amount toward basic health care for the uninsured. Individuals earning over 150 percent of the Federal poverty level would pay six-tenths of a percent of income up to the Social Security taxable maximum to support this program. It would be administered by State agencies whose structure would include representatives of payers, pro-

viders, and patients. UNAC would negotiate rates annually with providers. The self-employed and private employers could voluntarily join the UNAC program.

Employers, for their part, would be encouraged to continue to provide health insurance to their employees. The plan provides an incentive for all employers to offer insurance by setting a rate of 9 percent of Social Security wages, which would be paid into the UNAC program if coverage was not provided. Employees in firms which did not provide coverage would pay 2 percent of wages to participate in UNAC.

Basic benefits under UNAC would be defined in enabling Federal legislation. The commission anticipated coverage of basic medical and surgical benefits, as well as cost-effective preventive services, such as prenatal care.

States could enrich the basic package if they felt it desirable and affordable. The concept of the UNAC agency negotiating rates with providers includes within it a cost-control element which the commission considers very important: negotiation of payment rates in a cost-effective manner, made possible because the UNAC agency would be paying for a substantial number of people in each State.

Another cost-control element of the program is the national quality improvement initiative. This is an aspect of the commission's plan which would ensure that universal access will be provided to a higher quality of care than is generally available today. Under the initiative, outcomes research would be conducted on all major procedures, and national guidelines would be developed by physicians with funds from the UNAC premium dispersed by the Federal Government. These guidelines, which would indicate when major procedures are indicated, are unnecessary or are equivocal, would be available to patients and payers as well as providers of care. Better educated consumers would help both to improve the health care system and hold cost down. The availability of this information to the UNAC agencies would allow them to make the most informed buying decisions.

The quality initiative would be phased in over several years, gradually increasing the research, concentrating first on those procedures on which we spend the most money. The potential is there for major savings in the future.

And while we estimate $84 billion could be saved over the first year, even more would be saved as time went on. The quality initiative then would benefit both the private and public sectors and that way, there would be no attempt in shifting of services and costs from one payer to another, since all would share in the benefits of the national practice guidelines.

These efforts should be combined with a plan to expand current fragmented malpractice reform efforts. This would bring an end to the need felt by too many physicians and hospitals to practice defensive medicine and conducts tests and procedures beyond those which are necessary.

The result of all of these efforts, we believe, will be a strong public/private partnership, which will provide universal access to the basic benefits of care, while improving the quality of that care and taking actions to include cost-control elements in each aspect of the plan.

There are a lot of groups that are supporting this concept and some supporting this plan and we're heartened by that because we think the plan now has developed to the place where it is a focal point for national dialog and that's what we sincerely hope.

I'm not going to try to read all of this, Mr. Congressman, but let me just close by quoting one of our local citizens who certainly knows health care, and that's David Ramsey who is the president of the Iowa Methodist Medical Center here in Des Moines, our largest hospital in the State. This came as a result of him writing an obit for the Des Moines Register, unsolicited incidentally by me or anyone, and he talked about the commission and the commission's findings and conclusions and recommendations, and I want to quote. He says: "The commission's findings are extremely important. If the Federal and State governments, labor and business community back the recommendations, the cost of care will go down and the quality of care will go up."

Thank you.

Chairman TAUKE. Thank you very much, Governor.

Let us now move to the second witness on this panel, Paul Pietzsch, who is the president of the Health Policy Corp. of Iowa.

Welcome.

STATEMENT OF PAUL M. PIETZSCH, PRESIDENT, HEALTH POLICY CORP. OF IOWA, INC.

Mr. PIETZSCH. Thank you, Congressman Tauke, members of the Commission staff, ladies, and gentlemen. I thank you for this opportunity to appear before this distinguished Commission. Your mission to provide recommendations for closing the gaps in our Nation's health care system is very important to all of us. We believe this must be done from a comprehensive viewpoint. We support the development of thoughtful health policy direction and strategy for the United States that is designed to be broadly acceptable to our society. This strategy must address the whole system, offering financial protection from health care expenses, promoting the development of economic financing and delivery arrangements. It should provide a vision of a healthy society in the 21st century, one that promotes preventive health care, healthy lifestyles through vigorous public education, and an innovative, efficient health care system that provides access to a basic level of appropriate health care, affordable for all citizens.

The U.S. approach has relied on Medicare for the elderly, Medicaid for the poor, and individual and group health insurance for most other persons. Significant improvements are needed in all three.

I would direct my comments to Iowa and specifically the work—we've attempted to work in Iowa, using a broad-based task force. The Health Policy Corp. of Iowa [HPCI] is a broad-based, independent health coalition. The board of directors consists of Iowa leaders from the public and private sectors. HPCI began in 1982. Our purpose is to foster quality health care and financial protection for all Iowa citizens at a price that individuals and society can afford.

Since 1982, HPCI has been working on the various aspects of the health care equation of quality, geographic access, financial access,

and cost. I want to highlight the results and recommendations from two policy research projects we conducted during 1987 through 1989. Broad-based groups of Iowa leaders developed both reports. The first is entitled, Financial Access to Health Care in Iowa and the second, the Employed Uninsured.

Financing health care for those who cannot afford it because of poverty, lack of health insurance, or inadequate coverage has become a pressing public policy in Iowa and throughout the United States. The number of uninsured and underinsured Iowans is growing for many reasons. These include the cost of modern medical care, increasing cost of health insurance premiums, and the changing mix in employer types and their benefit programs. Iowa's health care—Iowa's charity care system, provided by Iowa hospitals and other providers is also undergoing change.

There are about 347,000 uninsured Iowans, or one in every eight. Of that group, about one-third are children under the age of 18. About two-thirds of Iowa uninsured, or 231,000 Iowans without insurance, are employed or dependents of an employed person. While the number of uninsured and underinsureds is not a new problem, it is a growing problem, obviously, throughout Iowa and the country.

Our task force recognizes the direct relationship between rising health care costs and the number of uninsured and underinsureds. Cost increases have affected the ability of individuals, families, business, and government to pay for health insurance or public programs. The ability of health care providers to provide free care or charity care is also being stretched. This prompted our task force to conclude the need for health care cost containment must be a high priority.

Additional highlights of our findings include the following: Uninsured and underinsured Iowans are not a homogenous group. This is important to recognize since the solution differs, depending on the subgroup of the uninsureds and their particular barriers and needs. Our study identified four separate groups of uninsureds and two groups of underinsureds. They are as follows:

Uninsured, the first subgroup will be the medically uninsurables. There are up to 42,000 Iowans in this category. These people are—have preexisting medical conditions which make them high risk and are usually not insurable under commercial insurance companies.

The second group are those who are employed, but uninsureds, including seasonal workers and part-time workers. There are perhaps 132,000 Iowans, age 18 to 64 in this group. They are predominantly low-income workers; 35 percent earn less than the federally defined minimum wage and over 75 percent earn less than twice the minimum wage.

The third group are the unemployed who are uninsured, between 18 and 64, that amounts to about 100,000 Iowans. These, for the most part, are single adults under age 65, childless couples, and parents in intact families. They are unemployed and not eligible for Medicaid due to being in an ineligible group under Medicaid.

The last group of uninsureds are children. Our task force fought very—this quite distinctly because there—one-third of all uninsureds are children under the age of 18. In Iowa, that amounts to

about 114,000 children. These are children who are not eligible, and their family is not eligible for Medicaid, yet they are not covered by insurance.

There is also, our task force identified two groups of underinsureds. That is, they have some public or private insurance, but not adequate to pay for medical expenses. The first group were those under age 65. In Iowa, that's up to half a million Iowans. Between 218,000 and roughly a half million, depending on your definition of underinsureds.

And the second group of underinsureds are those over age 65 who qualify for Medicare, who are on Medicare, but do not have other coverage, supplemental coverage and their incomes are not adequate to pay for noncovered expenses.

In Iowa, we estimate that to be about 140,000 Iowans under 65 and over.

Each group represents a unique situation and unique solutions. For example, the State of Iowa recently began a program aimed at the medically uninsurables. Efforts are also underway in Iowa to expand Medicaid eligibility for the poor and near-poor. This effort is especially aimed at infants, children, and pregnant women who are not insured.

The second finding we—from our task force is, about one-third of all Iowans are children under the age of 18. From any viewpoint—policy viewpoint, political viewpoint, societal viewpoint, or economic, this situation is inexcusable. And, from strictly an economic point of view, money spent on prenatal care and early childhood care pays good dividends for all of us.

The third finding we had for our task force is that there are many programs available which address the problems of low-income Iowans who are not insured. This included the State Indigent Patient Care Fund offered by the University of Iowa, hospitals and clinics, community mental health centers, community health centers, substance abuse programs, public health nursing, homemaker home health aid programs, maternal child health centers, and others.

The task force suggests that these programs should continue. The goal should be, however, to reshape them into a system up here that emphasizes people and their needs.

The fourth finding for our task force is that Iowa hospitals, physicians, and other health care professionals provide a lot of care that's called uncompensated care, or free care. We recommend that you give attention to issues surrounding uncompensated care provided by health care providers.

The task force recognizes and commends health care providers for this care. Yet, uncompensated health care provided by health care providers has never assured access to the uninsured. The major policy goal should be to assure access which is adequate for all population without health insurance.

The fifth finding is Iowa's long-term care system will be severely tested in the years ahead because of the growing number of elderly Iowans. The "frail elderly," that is, people over the age 85, are most at risk. They are most likely to require long-term care and their incomes are not adequate because of rising health care costs.

The recommendations and conclusions of our task force include eight specific recommendations. First of all, all Iowans have the right to adequate health care regardless of their financial ability. This should include preventive care and primary care services.

Second, the number of uninsured people in Iowa is growing rapidly. The lack of coverage limits financial access to health care. This especially impacts preventive care and primary care services. Most uninsured people in Iowa do receive emergency care.

Third, health care costs must be contained in order to realize our common goal of financial access for all.

Fourth, an overall strategy must have a goal of including everyone, yet at a pace that is realistic.

Fifth, the strategy should address issues from a multidimensional point of view. We recommend specific approaches for the following uninsured populations: One, for those who have the financial ability, either as individuals or through their employers; second, those below the poverty line who need comprehensive care and minimum out-of-pocket expenses. This should be the governments' responsibility to finance. And third, those who are between these two groups which require a shared responsibility for financing.

Sixth, we recommend changes to Medicare and Medicaid legislation so that Medicaid reemerges as a financing mechanism for delivery services for low-income families and that Medicare funding concentrates on financing needs for elderly, including long-term care.

Now, Medicaid, which is originally designed for low-income citizens, finances about half of all nursing home expenses. At the same time, Medicaid serves less than 50 percent of the poor and near-poor in this country.

No. 7, funding should be broad based and fair. Everyone should bear their fair responsibility of cost and other responsibilities. The private sector should work in partnership with government to define the appropriate role of each.

Specifically, we recommend continued reliance on private insurance, including employer-based programs. The Federal Government should expand Medicaid eligibility. The task force also suggests and recommends a State-level, public-sponsor group for the near-poor. That is, people above federally defined poverty.

We also recommend that individuals should take an increased responsibility for their own health, including making appropriate lifestyle changes.

And last, we recommend that health care should continue to be bought and sold locally, not delivered through a federally operated public utility.

You will find additional recommendations and details in our two reports. One approach in our report calls for quickly reducing or eliminating the number of employed uninsureds. The second urges a more cautious approach.

Another alternative, as described by Governor Ray this morning, from the National Leadership Commission, and also by Uwe Reinhart, Princeton University and Alain Enthoven, Stanford University in a recent New England Journal of Medicine article, describes another approach which has great merit. It basically calls upon all individuals to have health coverage as their responsibility, yet

makes available public, affordable programs and policies for all Iowans and Americans. To control the cost of this program, benefits would be delivered through qualified managed care systems such as preferred provider organizations, health maintenance organizations, using competitive bidding contracts. It uses a consumer-oriented, market-based, competitive health care system approach.

In conclusion, some would say it would be fiscally irresponsible to grant access for all uninsured and underinsureds in the current inflationary system of financing and delivery. Others say it is morally irresponsible not to. Perhaps both have good points. The issue of how to pay for costs still remains an unanswered question. Will we advocate a Canadian-style system or move forward on a public/private consumer-oriented, market-based competitive health care system like those described by Enthoven, Reinhart, and the National Leadership Commission? Right now, there is a need for consensus in a direction for the national health policy. Congressional and administration leadership is needed. Your Commission will play an important role in this.

Thank you for this opportunity to share our findings.

Chairman TAUKE. Well, thank you, very much, to both of our witnesses for their excellent testimony. I have a few questions, and I think Ed may have a few as well.

First of all, Governor Ray, I think you know that the Commission is currently attempting to put the recommendations of your commission into legislative form so that we can have a piece of legislation which embodies the recommendations of the commission. It appears to me, as I look at your testimony, that one of the striking things that you indicated was that there would be a doubling of health care costs in the next 6 years, and I believe your report also suggests that there would be a quadrupling of costs over the next 12 years.

Do you think that the recommendations of the commission would substantially change that pattern of inflation and health care costs?

Governor RAY. We think so. I certainly think so and the commission thinks so. And that's the reason we are so determined to promote the three factors as a solution and you eluded to it in your opening comments, that if we provide access for everybody, which is certainly commendable, and do nothing else, you're going to have a bigger problem because you cannot control cost if you don't do something about cost and providing access alone will not do that.

So, it's a vicious circle if you don't deal with all three aspects of the problem. It is estimated that if nothing is done, it will only take 70 years before the entire gross national product is for health care. Now, you and I know that can't happen and won't happen, but it tells you about the magnitude of the problem. And so, we feel very strongly that you must deal with the quality.

When Bud Relman of the New England Medical Journal, and I quoted him a moment ago, said 30 percent of the procedures and care is either unnecessary, inappropriate, and sometimes harmful, that's $150 billion and we can't continue that way.

And in fairness to the providers, they need an additional research, and they need additional study made available to them and

you find the practice will change if doctors have adequate evidence that there's a better way to provide service for their patients.

So, we think that you have to deal with all three of those critical elements and if you do, as we propose or something similar to that, then you can get a handle on it and it is absolutely imperative that that happen.

Chairman TAUKE. In Mr. Pietzsch's testimony, he talked about the medically uninsurable, and I know as a CEO [chief executive officer] of an insurance company, Blue Cross/Blue Shield, you obviously run into that problem on an ongoing basis—how to deal with the medically uninsurable.

In a sense, that seems to be one of the more difficult problems. What does your commission recommend in dealing with the medically uninsurable?

Governor RAY. Well, I think the UNAC Program would be large enough that it can absorb some of those presently uninsurable. In the State of Iowa, we do have an uninsurable pool which people can go into and pay a premium. Unfortunately, for the insurance companies, it is very, very costly because they pay, as I recall, 150 percent of the average premium, which is not sufficient to cover those people who can't buy insurance through the regular channels. But if you have a broad enough base, then you will be able to absorb many of those people, or all of those people.

Chairman TAUKE. You, as a former Governor, I'm sure there are times when you like to see flexibility at the State level, but I am sure there are times also when Governors get very nervous because the Federal Government keeps dumping additional responsibilities on State governments.

One of the areas in which there is a lot of concern right now is in the whole Medicaid area, that the Federal Government has a partnership with the States. Some States provide much more care for low-income individuals than other States do, and there is wide disparity from State to State in the kind of coverage that is offered through the Medicaid Program.

Do you think that as we look to the future, we should be looking at a program that is national; should we be looking at a program that is a combination of national and State where the State has some judgments about the extent covered for its citizens, or should we place, put, tend to move to providing assistance to States, but letting them design their own programs? So, what's the proper Federal/State mix here?

Governor RAY. Well, our commission dealt with that specific problem and we believe that this is a national problem, not just a State problem. And we believe there is tremendous cost shifting going on within States and outside of States.

We believe that there has to be a basic minimum coverage for every American and you can't do that by piece mealing it, you can't do it by saying every State, you just decide on your own and then we'll send you money. That's not going to work.

Now, we did provide, however, that after you cover the basic plan, basic benefits program, then States would be allowed to enrich that program if States wish to do that. That would be their perogative. But I don't think that anybody on our commission believed that you could just say, let's continue as we have in the past

and every State do just exactly what it wishes to do if you're going to take care of this very, very serious problem.

Chairman TAUKE. Mr. Pietzsch, you talked in your testimony about establishing a partnership with providers of insurance, and the Governor talked about that in his testimony as well. How do we establish—I know you've had, some challenges doing that with the Health Policy Corp. of Iowa. Not to put you on the spot or anything, but what, what advice do you have for us in trying to develop partnerships. Maybe Governor Ray would have a comment or two on that also?

Mr. PIETZSCH. We've had an opportunity to reflect on that the last 6 months or so in Iowa as you may know. I think one of the key roles, from our point of view today, is that we need to have a better understanding of definition of each role—each of the roles and responsibilities. That is, roles of health care providers, doctors, and hospitals and their role of responsibility, the consumer's role of responsibility for good health and lifestyle and so forth, the government's responsibility, and the private sector's responsibility.

And I think part of our challenge here in this country trying to make a public/private partnership work as opposed to a national system is, we have to get a better definition of those roles that State government, National Government, and the private sector, including health care providers, or obviously, things would be stressed to a point down the road where, where they will be a national system and other frustration perhaps.

So I think we are—one of the things we are trying—working on right now in Iowa is to define specifically roles and responsibilities of the different groups that you mentioned.

Chairman TAUKE. I did want to commend you for your emphasis on prenatal and early childhood care. I serve on the Infant Mortality Commission of Congress as well, and we find that for every dollar expended on prenatal care and early childhood care that there is about a $6 return on that investment. So, if we can keep getting that message out, I think that's very good.

It seemed to me that the recommendations which you talked about in your testimony were quite similar to the recommendations of the commission which Governor Ray headed. Is that a correct assessment?

Mr. PIETZSCH. I think that's very, very correct. We held a roundtable early this year and brought in leaders from throughout the State, from all walks of life and Governor Ray had an opportunity to present the commission report in some detail and it was very well received by a broad base of our leaders. So we look forward to working on the recommendations from that report, both here in Iowa and to supporting national level work as well.

Chairman TAUKE. I heard from both of you, comments about individual responsibility, that people had to have some responsibility for their own lifestyles, but I didn't hear much in the way of what we do. Obviously, a lot of people engage in lifestyles that are very unhealthy and there is resistance to allowing them to then dump all their health care costs on everybody else. What do we do to encourage better lifestyles, are you suggesting, for example, that maybe if people engage in certain kinds of activities that they would be in some way carved out of the system? What are you

saying when you talk about better lifestyles and personal responsibility?

Governor RAY. Well, I think we'll just use you as an example. You live a healthy life, exercise, you eat properly, don't smoke, don't drink, I think.

I think that's one of the problems in this country. We always are comparing the results of our health care system with the results of the health care system in other countries and I think we have to realize that, first of all, we pay for a lot of technology in this country. We have an aging population which causes a higher cost for medical care because we're living longer. And then we have drugs and we have AIDS and we have some very serious problems that are very, very costly. Smoking alone is just startling in what it costs in the way of lives and human misery. So we have some reason why our health care costs are much higher, not to mention malpractice insurance or liability.

I think we have to continue to do some of the things that have begun in this country and that is, to convince people that their lifestyles depend upon what their health style might be. They must exercise, they must eat more appropriately, and they must stay away from drugs.

Now, that's a slow process; smoking being an example. But there are a lot of people who have given up smoking and it has taken years to get to the place where they really are conscious of that as a serious problem. We cannot wait until lifestyles change. I think we have to move swiftly if we're going to do something about cost containment and at the same time provide better care and more quality. But we have to keep this piece hooked into the overall program because we do believe that individuals have to shoulder some of this responsibility themselves and that's the reason this program, incidentally says, not that every employer has to provide coverage for every employee, but the employee has that responsibility. And if it's over the bargaining table that they get the employer to pay or whatever the circumstance might be, every individual has to be conscious of his or her health needs and so I think it's a long, educational process.

Chairman TAUKE. Paul?

Mr. PIETZSCH. I've heard experts predict recently that just like the decades of the 1970's and 1980's, the decades of medical care, the decades of the 1990's and 2000's will be the decades of lifestyle and wellness. I hope that's true in terms of emphasis. I think we're just seeing research results now which show the dramatic benefit of healthy lifestyle and wellness programs in other efforts along that line.

And we're finally seeing business and industry, State government, and others pick up, pick up the torch and develop wellness programs within our companies. Worksite wellness, for example, and other efforts, which will bring people along to the benefits of those programs. I think it's just going to be an educational process as the Governor mentioned, but there's great, great dividends to be found there because it's a lot easier to prevent something from happening than to patch someone up afterward. And in all aspects of medical care, that's the case.

Governor RAY. Having run a company, I might say, Congressman Tauke, it is not easy because we have designed programs to help people, to encourage people; we paid for programs to get them involved in wellness programs and fitness programs and unfortunately, the young sport, the healthy specimen will participate freely, but the person that's obese and needs it most will not and it's pretty difficult—in fact, it's impossible to order somebody into a fitness program. And so, many of the people that need it the most are the ones that are most reluctant to participate.

Chairman TAUKE. Well, do you think, putting it bluntly, there should be some kind of a penalty that an individual pays who uses drugs, let's say, or who engages in unhealthy lifestyles?

Governor RAY. Well, it's an age-old problem. Do you penalize them or do you work with them and help them shake the habit. You know, that's always a tough call.

But one thing we know with certainty is that there are a lot of children that are adversely affected and that's the reason we're 19th in the world when it comes to infant mortality and that's, to me, disgraceful. But the drug habit itself is responsible for much of that.

Chairman TAUKE. Ed, do you have any questions?

Mr. HOWARD. Just one question for Mr. Pietzsch, if I may. Let me give you a chance to help define that specific level of detail you were talking about in your plan.

Has your task force decided how far up the income scale you'd like to see a Medicaid buy-in or a State level, public-sponsored program go to provide universal access?

Mr. PIETZSCH. As far up as we can afford. I guess—there are different numbers. First of all, I think the key there is to understand right now in this country, even though we have Medicaid, which is by definition, established way back in the mid-1960's to provide care to the poor and near-poor in this country, today, less than 50 percent of those under Federal defined poverty wages are even eligible for Medicaid today. So, we've got—if we can get from 50 percent up to 100 percent of poverty, we're making great strides, but we have to go beyond that. I think we're basically saying that Medicaid ought to go back to its original program of providing care for the poor and near-poor and every State in the country should have at least, should at least go up to 100 percent of poverty as definition.

Then, on top of that, there ought to be some sort of State-sponsored pool that goes, maybe up to 150 percent of poverty, or even 200 percent of poverty, to cover the near-poor in this country, with emphasis on, on infants and children and pregnant women, but everyone.

Mr. HOWARD. Thank you, Mr. Chairman.

Chairman TAUKE. Thank you, gentlemen. We appreciate very much your testimony.

Mr. PIETZSCH. Thank you.

Chairman TAUKE. I now would like to call the next panel of witnesses: Debbie Gansemer, Mark Kennis, and Ray Morgan.

We thank the witnesses on this panel for their willingness to share with us their own personal experiences in attempting to get adequate health care coverage.

Debbie Gansemer is accompanied by her husband, Frank. Debbie, would you like to begin.

STATEMENT OF DEBBIE GANSEMER, DURANGO, IA

Mrs. GANSEMER. Hello, my name is Debbie Gansemer. I am a housewife with four children. My husband, Francis, is a farmer. My oldest child, Bryon, 8, has cerebral palsy and is wheelchair bound, but is otherwise healthy. I am thankful to say my other children, Sarah, Joshua, and Scott are all healthy.

We were all covered, including Bryon, by Blue Cross/Blue Shield of Wisconsin. But when the premium went up to $465 per month, we could no longer afford it. We were able to get insurance through PMA Insurance for everyone except Bryon. We tried to get coverage for Bryon from an HMO [health maintenance organization] and a variety of other health insurance companies. We even enlisted the help of a physician who went to the insurance executives and told them that despite the fact that Bryon has cerebral palsy, he is healthy, but it made absolutely no difference. We now pay $190 per month for health insurance for the rest of the family and Bryon has Medicaid.

We don't have to pay for Bryon's Medicaid, but it does restrict our family's income. Because of the strict Medicaid rules, if our family income goes above a certain level, Bryon loses his coverage. My husband would like to expand in farming and I would like to get a job to help out. But the potential danger of having an uninsured handicapped child is too great for us to gamble, so we'll make sure our income stays below the limit. If things keep going the way they are, we will all, as a family, be a financial burden to the government.

This discrimination against the handicapped must end. A national system to provide health care coverage for all Americans, including the handicapped, must be developed. The current system holds individuals and their families back by forcing tradeoffs between personal success and adequate health care coverage. It is a great frustration for my family and others like us.

I hope that your Commission will help us. [Applause.]

Chairman TAUKE. Thank you very much, Debbie.

Mark Kennis.

STATEMENT OF MARK KENNIS, GRIMES, IA

Mr. KENNIS. Hello. My name is Mark Kennis. I am from Grimes, IA. My wife and three children, David, 14; Destiny, 6; and Matthew, 5, are all uninsured. I receive medical care through the Veterans Hospital system. I am totally disabled due to diabetes and seizures which are related to my diabetes. My wife is self-employed as the editor-publisher-distributor of Iowa Lady Magazine. Our annual income is approximately $11,000.

To receive care through the VA system, you must show that you are poor and that you are not covered by any other insurance plan. In addition, much of your care is determined by the limits that result from the annual appropriation process in Washington, DC.

I am also in the process of trying to get coverage under the Federal Disability Program. My disability is not service-related. Conse-

quently, I fall into a lower priority group in the VA system. It is important that I receive coverage under the Federal Disability Program, as I have been told that my condition is likely to deteriorate over time. If I don't receive assistance through the Federal Disability Program and the Medicare assistance that accompanies it, I don't know how my family will be able to afford care for me should I become sick. In the meantime, I continue to use the VA system.

My wife is self-employed and is the primary wage earner in our household. She has tried to find affordable health insurance for our family, but has been unable to do so because of our low income. As a result, she does without needed health care. We do the best we can for our children. When they need medical care, we pay for it out-of-pocket. As a result of my diabetes, I need special eyeglasses and I also need dental work done. These services are not covered by the VA system, and at present time, I cannot afford them. School will be starting soon and we have to buy school supplies and clothes.

I am here testifying before this Commission today because I want a better America for my children. An America where they won't have to worry about how they will pay for care when their children get sick. Or how they will care for themselves and their families should they become disabled. I'm here to testify that lifelong, chronic illness such as the ones I have can strike anyone at any time [applause] and when they do, the medical insurance system that our Nation currently has absolutely does not work. [Applause.]

I believe that there should be a national insurance policy for everyone. It should be easy for people to access and responsive to people's needs. I hope that this Commission will help get us there. Thank you. [Applause.]

Chairman TAUKE. Thank you, Mr. Kennis.

Our next witness is Ray Morgan from—a small employer, Morgan's Sanitation in Algona, IA. Ray.

STATEMENT OF RAY MORGAN, OWNER, MORGAN'S SANITATION, ALGONA, IA

Mr. MORGAN. Good morning. My wife and I are owners of Morgan's Sanitation located in Algona, IA. I am a lifelong resident of Iowa. My parents started our business back in the late 1950's and my wife and I have been active in that business since 1962 and we've been in the garbage disposal business for the past 18 years.

I am here today to discuss the problems my small business has encountered with rising health care costs and, in a sense, to represent the 14,000 Iowa members and 570,000 nationwide members of the National Federation of Independent Business. Those members, myself included, oppose mandated health insurance and other "disincentives" such as payroll and excise taxes, but believe that something should be done to make health care and health insurance more affordable. I would like to thank the Commission for taking the time to come here to Iowa to learn about the problems that small businesses are encountering in this area.

But let's talk about my problems—my business. We employ nine persons, two part-time and seven full-time, including my wife and myself. We are organized as an S-Corporation and provide health

insurance to all of our full-time employees. The insurance includes the standard coverages as well as dental care, complete family coverage, disability protection, and life insurance. My employees are not asked to make any contribution toward premiums. We pay 100 percent of those premiums, even the dependent coverage. The two part-time employees are not covered because of their limited hours spent in our business. One is a high school girl working part-time in the Office Education Program and the other is an employee who works only a half-day on Saturdays.

In approximately 10 years, we have had three health insurance carriers. The first was dropped in July 1988 after almost 9 years of coverage after significantly increasing the premiums by 57 percent, or $837 per month. Unfortunately, changing carriers did not keep my premiums from further increasing.

The second carrier began coverage in August 1988. The premium was a pure group coverage like the first policy, meaning that the policy would insure all of my employees and their dependents regardless of insurability. For all seven employees, the premium in August 1988 was $1,470 per month. This was swiftly followed by a 4-percent increase in September 1988, bringing the total premium to $1,525 per month. Again, in May 1989, the premium was increased to $2,231 per month and again increased to $2,685 in July 1989. From August 1988 until July 1989, my insurance premium had been increased 83 percent. In addition to the premium increases, the insurance carrier also increased the deductibility for my employees from $100 to $250 and increased the coinsurance cap from $5,000 to $15,000. Those changes made the insurance more costly for my employees as well as to me.

During the 10 months with this carrier, there were no major claims made by any of my employees, myself, or my wife—no surgeries, no catastrophic illnesses, no pregnancies. We essentially had a clean bill of health. Upon contacting the carrier to discover the reasons for the increases, I was told that the increases were to "keep pace with today's escalating health care costs." Eventually, we were given a counterproposal to attempt to lower the rates. That proposal required us to provide evidence of insurability for all our employees and dependents. While that arguably would not be difficult, the past experience of my business should have been enough evidence for the carrier.

I have since left that company and gone to another carrier. The current premium is $1,634 a month, or $19,608 per year, not including any premium increases that may come in this year. That is still an 11-percent increase over my August 1988 premium with no claims or illnesses to justify even that increase, in my opinion. The current carrier will not guarantee rates more than one calendar quarter at a time. It simply appears to be the old game of "sorry, it could have been worse."

Each of these changes takes time away from my business. I own a very small business with no benefits manager. I cannot afford to hire a health research assistant or someone to research the plans for me. My wife and I must take time away from other duties, other aspects of the business to contact local independent insurance agents, negotiate with them, and research the various plans that are available to small firms.

Throughout the process though, I discovered I essentially had four options: First, I could have my employees contribute to the premium costs. I did not think that would be fair when I am providing health insurance as a benefit. To require a contribution would effectively be a pay decrease for my employees, at least in their minds. So I rejected this option.

Second, I explored the IRS medical reimbursement plan as provided in the Internal Revenue Code, section 213. This provision permits the employer to set up a medical cap each year. The employee submits his or her bills to me for payment up to the capped dollar amount. After the limit, the employee pays the remaining bills. The business would then get some tax advantage for setting up the plan; also, the employee. I did not like this program because of its complexity and the paperwork problems, in my mind, that it presents.

Third, I could drop the plan altogether and give each of my employees a stipend to purchase insurance on their own. Not only would this be unfair to my employees, it would also force at least one of my key employees, who considers his health insurance a benefit, to leave, or to at least look for other employment.

Finally, I could keep trying to find a plan that I could afford and one that wouldn't continually increase my premiums. Obviously, this was the only true option available, but it may not be a feasible one in the future. Premiums of $1,600 per month—over $19,000 per year—is a lot of money for a company such as mine that takes in less than a half a million dollars in receipts each year.

Although, on the positive side, at least I had the above options. If the Congress or the State legislature were to mandate insurance coverage, these options would disappear and so would some of the jobs in my business. Health insurance which should remain a fringe benefit and not a mandatory benefit.

I also do not support any disincentives, even for firms that do not provide health insurance. The proper approach should be to provide small firms and entrepreneurs with incentives, such as additional income tax credit, or credit against payroll taxes. A tax credit with minimal paperwork and complexity, would help those firms provide insurance that currently do not do so and help businesses like myself afford health insurance. As an alternative, the Commission should consider a tax deduction greater than the premium amount, such as a deduction of 150 percent on our income tax.

I believe that most small businesses would like to provide health insurance to their employees, but simply cannot afford it. If incentives are provided and costs contained, more would provide health insurance as a fringe benefit. I would like to reiterate that any incentive must be simple to administer and have little or no paperwork. I am already deluged by Government paperwork and forms that I simply do not know how to comply with and I would raise as an example that section 89 of the IRS Code. [Applause.]

In conclusion, I believe that we somehow need to reduce medical costs. Medical costs are rising faster than inflation and faster than anything else. This was recently brought home to me when one of my employees submitted an x ray bill for his worker's compensa-

tion claim. For less than 15 minutes in the doctor's office, the bill was $95. Something is out of whack here. [Applause.]

Medical costs need to be contained and until that is done, small businesses like myself will continue to be hit with health insurance premiums that are getting to be unaffordable.

Thank you for the opportunity to testify before you today. [Applause.]

[The prepared statement of Mr. Morgan follows:]

NFIB

National Federation of
Independent Business

SUBMITTED STATEMENT

OF

RAY MORGAN
MORGAN'S SANITATION
ALGONA, IOWA

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: Pepper Commission, Iowa Field Hearing

Subject: Health Insurance Cost

Date: August 21, 1989

Good morning. My name is Ray Morgan. My wife and I are the owners of Morgan's Sanitation located in Algona, Iowa. I am a life long resident of Iowa. My parents started the business in the late 1950s and my wife and I have been active in it since 1962; we have been in the garbage disposal industry for over 18 years.

I am here today to discuss the problems my small business has encountered with rising health insurance costs and to represent the 14,000 Iowa and 570,000 nationwide small business owner members, of the National Federation of Independent Business (NFIB). NFIB members, myself included, oppose mandated health insurance and other "disincentives" such as payroll or excise taxes but believe that something should be done to make health care, and health insurance, more affordable. I would like to thank the Commission for taking the time to come here to learn about the problems small businesses are encountering in this area.

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The Guardian of
Small Business

My business employs 9 people -- 2 part-time and 7 full-time employees including myself and my wife. We are organized as an S-Corporation and provide health insurance to all of our full-time employees. The insurance includes the standard coverages as well dental care, complete family coverage, disability protection and life insurance. My employees are not asked to make any contribution towards the premiums -- we pay 100% of the premium, even for dependent coverage. The two part-time employees are not covered because of their limited hours spent at the business: one is working as part of a high school education program and the other works a half-day on Saturday.

In approximately the past 10 years, I have had three health insurance carriers. The first carrier was dropped in July, 1988 after significantly increasing the premiums by 57% or $837.05/month. Unfortunately, changing carriers did not keep my premiums from further escalating.

The second carrier began its coverage in August, 1988. The premium was for "pure" group coverage like the first policy, meaning that the policy would insure all of my employees and their dependents regardless of insurability. For all seven employees the premium in August, 1988 was $1470.69/month. That was swiftly followed by a 4% increase in September, 1988 bringing the total premium cost to $1525/month. Again, in May, 1989 the premium was increased to $2231/month and again increased to $2685/month in July, 1989. From August, 1988 until July, 1989 my premium had been increased by 83%. In addition to the premium

increases, the insurance carrier also increased the employee deductible from $100 to $250 and increased the coinsurance cap from $5,000 to $15,000. Those changes made the insurance more costly for my employees as well as to me.

During the ten months with this carrier, there were no major claims made by any of my employees, myself or my wife -- no surgeries, no catastrophies and no pregnancies. We essentially had a clean bill of health. Upon contacting the carrier to discover the reasons for the increases, I was told that the increases were to "... keep pace with today's escalating health care costs". Eventually we were given a counterproposal to attempt to lower the rates, that proposal required us to provide evidence of insurability for all of the employees and their dependents. While that arguably would not be difficult, the past experience of my business should have been enough evidence for the carrier.

I have since left that company and gone with another carrier. The current premium is $1634/month or $19,608/year (not including any premium increase) for my business. That is still an 11% increase over my August, 1988 premium with no claims or illnesses to justify even that increase. The current carrier will not guarantee rates more than one calendar quarter at a time. It appears to be the old "sorry, it could have been worse" game.

Each of these changes takes time away from my business. I own a very small business with no benefits manager. I cannot afford to hire someone to research health insurance plans for me. My wife or I

must take time away of other aspects from the business to contact local independent insurance agents, negotiate with them, and research the various plans that are available to small firms.

Throughout this process, I discovered I essentially had four options:

First, I could have my employees contribute to the premium costs. I did not think that would be fair when I am providing health insurance as a benefit. To require a contribution would effectively be a pay decrease for my employees in their minds. I rejected this option.

Second, I explored the IRS medical reimbursement plan (IRC 213). This provision permits the employer to set a medical expenditure cap each year. The employee submits his/her bills to me for payment up to a capped dollar limit. After that limit, the employee pays the remaining bills. The business would then get some tax advantages for setting up the plan. I did not like this program because of its complexity and paperwork problems.

Third, I could drop the plan altogether and give each employee a stipend to purchase insurance on their own. Not only would this be unfair to my employees, it could also force at least one of my key employees to leave.

Finally, I could keep trying to find a plan that I could afford and one that wouldn't continually increase my premiums. Obviously, this was the only true option available but it may not be a feasible one in the future. Premiums of $1600 plus/month (or over $19,000/year) is a lot of money for a company that takes in less than a half-million dollars in receipts each year.

On the positive side, at least I had the above options. If the Congress, or the state legislature, were to mandate insurance coverage these options would disappear and so would some of the jobs in my business. Health insurance should remain a fringe benefit not a mandatory benefit.

I also do not support the idea of "disincentives", even for firms that do not provide health insurance. The proper approach should be to provide small firms and entrepreneurs with incentives, such as a an additional income tax credit or a credit against payroll taxes. A tax credit, with minimal paperwork and complexity, would help those firms provide insurance that currently do not do so and help businesses like myself afford health insurance. As an alternative, the Commission should consider a tax deduction greater than the premium amount, such as a deduction for 150% of premium costs.

I believe that most small businesses would like to provide health insurance to their employees but just cannot afford it. If incentives are provided and costs contained, more would provide health

insurance as a fringe benefit. I would like to reiterate that any incentive must be simple to administer and have little or no paperwork -- I am already deluged with government paperwork and forms that I simply do not know how to comply with.

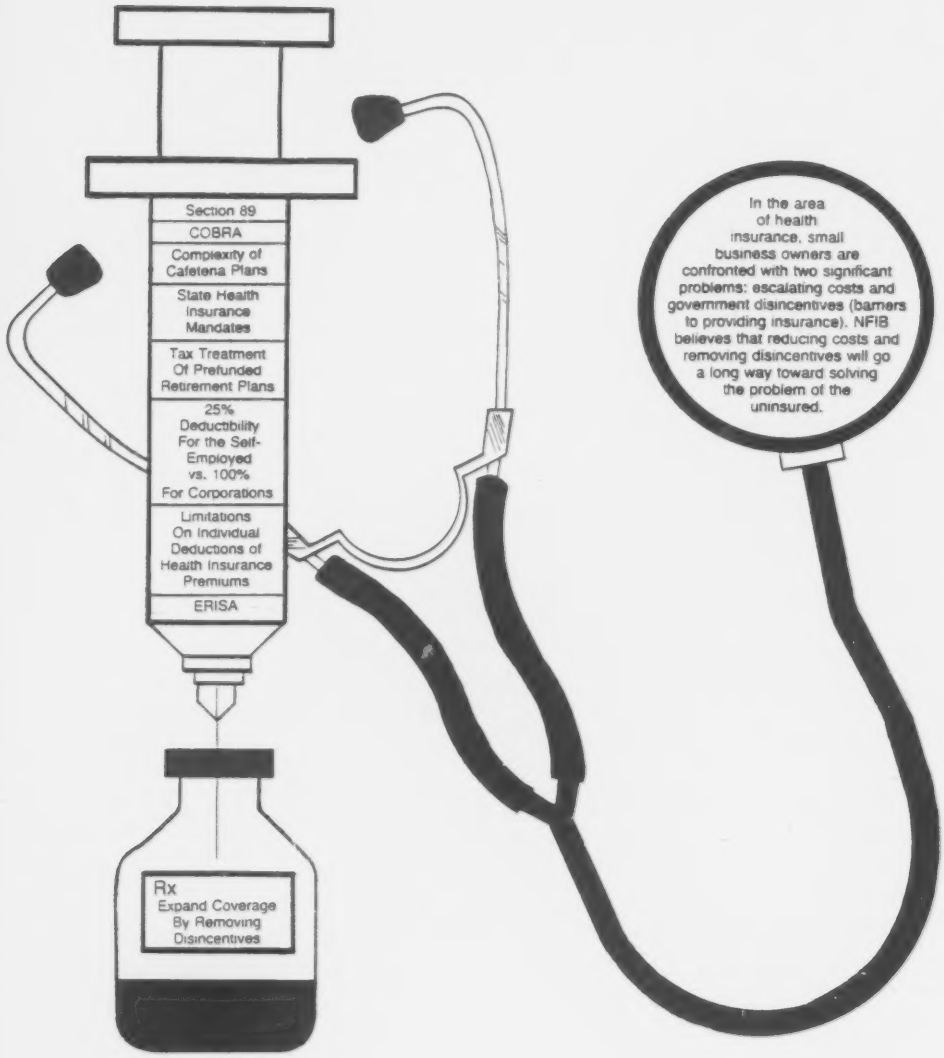
In conclusion, I believe that we somehow need to reduce medical costs. Medical costs are rising faster than inflation and faster than anything else. This was recently brought home when one of my employees submitted an X-ray bill for his worker's compensation claim -- for less than 15 minutes in the doctor's office, the bill was for $95. Something is out of whack here. Medical costs need to be contained and until that is done, small businesses like myself will continue to be hit with health insurance premiums that are getting to be unaffordable.

Thank you for the opportunity to testify before you today. I have attached a chart from the NFIB that outlines some of the incremental changes that could be made to lower the cost of health insurance for small businesses.

0365T

Attachment

Government Disincentives To Small Businesses Providing Health Insurance


Section 89
COBRA
Complexity of Cafeteria Plans
State Health Insurance Mandates
Tax Treatment Of Prefunded Retirement Plans
25% Deductibility For the Self-Employed vs. 100% For Corporations
Limitations On Individual Deductions of Health Insurance Premiums
ERISA
Rx
Expand Coverage By Removing Disincentives
In the area of health insurance, small business owners are confronted with two significant problems: escalating costs and government disincentives (barriers to providing insurance). NFIB believes that reducing costs and removing disincentives will go a long way toward solving the problem of the uninsured.

NFIB's Antidote (Our

The Uninsured—A Problem?

Providing health insurance is much more costly for a small business than for a large business. Out of 75 issues polled in a 1986 survey the cost of health insurance ranked as the number one problem facing a small business. Subsequent surveys indicate that this concern remains at the top.

Rapidly rising costs are the disease, and the increased number of uninsured individuals are the symptoms. Cost containment—making health insurance premiums affordable for businesses—would go a long way toward solving the problem of the uninsured.

NFIB's Four-Part Antidote

Repeal Section 89. One of the effects of this tax-code provision has been to drive up the costs and administrative burden of providing health insurance to such an extent that many small- and mid-sized firms are simply dropping their plans rather than attempting to comply with the tangle of complex anti-discrimination tests.

Repeal COBRA. This once-touted "cost neutral" plan has turned into an expensive proposition. Under the Consolidated Omnibus Budget Reconciliation Act, former employees—to continue coverage for themselves and their dependents—pay 102 percent of the premiums for 18 to 36 months. The increased adverse selection and risk associated with the continued coverage has made this benefit expensive for small firms. NFIB members indicate that COBRA has driven up the costs of their health plans for current employees as much as 300 percent, and some firms have seen their plans dropped by their insurance carriers.

Increase to 100 percent the deduction for the self-employed. The tax code discriminates based upon the form under which a business is organized. Currently self-employed business owners can deduct only 25 percent of the cost of their health insurance as a business expense. Less than 40 percent of America's businesses are organized as corporations. Approximately 20 percent of the 37 million uninsured could benefit from this change in the tax code.

Repeal state mandates. Bypassing state health-insurance mandates would permit insurance carriers to offer "bare bones" or "no-frills" insurance plans to small businesses. The American Health Insurance Association estimates that state mandates increased health insurance costs in the state of Maryland, which has 32 state health insurance mandates, 20 to 25 percent. A Texas policy group estimates that one of every four uninsured persons lacks insurance because of state insurance regulations, primarily state mandates.

For more information on these pro-active measures to increase health insurance coverage for both employers and employees, call NFIB, the National Federation of Independent Business, at 554-9000.

NFIB National Federation of Independent Business

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Chairman TAUKE. Well, thank you, all, for your testimony. I really appreciate your willingness to step forward and tell your stories. I can tell you that there are many Iowans who come to my office and the offices of the other Members of Congress with similar stories, but it takes a considerable amount of courage to be willing to come forward in public and you all did it very articulately.

Let me ask just a couple of questions.

First of all, Mr. Kennis, could you tell us a little bit about what your experience has been with Social Security disability. I understand you have applied for Social Security disability. Are you in that process right now?

Mr. KENNIS. Yes, I am. The redtape that you run through is absolutely incredible. We've been in that stage for 2 years now by going to various doctors for examinations, being turned down, and appealing. I understood from an article—I don't know if I'm quoting properly—it was in the Des Moines Register—that it's almost automatic the first time anybody appeals for Social Security, they are automatically turned down. [Applause.]

Now, maybe it's their job to turn people down for that, but what they're doing is, they're messing with people's lives and it's very, very difficult for them to handle this situation under those circumstances. There are people that are disabled that don't have money coming in, so how do they live for those 2 or 3 years while they fight the appeals process.

Chairman TAUKE. Are you in the appeals process right now?

Mr. KENNIS. Yes, I am. I've been through—I've done everything they've wanted me to. I've gone—they've asked me to go to the Vocational Rehabilitation Center in Des Moines and I've done that for them. I've been to several of their doctors that they've sent me to. I've done everything they've asked. So, I wait. And still my family is uninsured; my children don't have insurance and we sit there and wait for something major to happen. It's a terrible process to sit there and wonder that if something happens, you don't have any way of handling the situation or money to pay the doctor bills.

Chairman TAUKE. Now, in your situation, the rest of your family also does not have health insurance, is that correct?

Mr. KENNIS. Well, health insurance is expensive and because I'm not employed and because I don't have Social Security money coming in, we don't have the money to pay the high insurance premiums. So, we're between a rock and a hard place.

Chairman TAUKE. So, even if you are covered by Social Security disability, we still have the additional challenge of how to provide coverage for your family?

Mr. KENNIS. I believe that is correct.

Chairman TAUKE. Mrs. Gansemer, your situation reminded me of the story that we will hear in the next panel of Katie Beckett because you have a somewhat similar situation, a child who has special health care needs and perhaps, in your case, many of those needs are somewhat past him, but he still is perceived as having special health care needs.

Now, he is on Medicaid, but because he is on Medicaid, that affects your total family income.

Mrs. GANSEMER. Right.

Chairman TAUKE. And if your family income rises above the Medicaid permissible levels and you lose, he loses the Medicaid insurance——

Mr. GANSEMER. Everybody loses. And it also includes—it's not just my income. If the kids, my kids, the other three kids that are, quote, normal, would happen to get a job and they put that money away and bank it themselves, since they are under the age of 18, that is then counted against me for income, which should not be. That's more or less telling the kids, why should you want to go out and work, you know. It's more or less, it's not—I don't know how to say it——

Mrs. GANSEMER. Plus, we can't have stock of our own, life insurance. It's just holding us down. They don't want us to get better.

Mr. Gansemer. It's almost like they want to hold you at the poverty level and you cannot get any better. If you get any better, you're sitting with a child, he has no problems, but problems can arise and then what happens?

Chairman TAUKE. So, in your case, the key is, to change the Medicaid rules so that he could stay on Medicaid without penalizing the rest of the family.

Mrs. GANSEMER. Without penalizing the rest of the family.

Chairman TAUKE. Mr. Morgan, I marked something in here that I wanted to ask about.

You indicated that one of your employees would be likely to leave if that employee received a stipend to purchase insurance on his or her own. Is that because that particular employee has a challenge getting insurance, or simply because that employee doesn't want to face the challenge that you're facing when they receive a stipend of a certain amount but then see their cost skyrocket while the stipend remains relatively constant?

Mr. MORGAN. It's a combination of both, Congressman. His wife has a heart murmur problem, but also insurance to purchase on an individual basis is much higher than through a group. So, he would be faced with probably paying more than the stipend and so it would be effectively a pay decrease. And so, it's a combination of both.

Chairman TAUKE. Is there any kind of a larger pool of small businesses that you can get into where groups of small businesses try to purchase health care insurance and through the volume of the business are able to get better rates?

Mr. MORGAN. We have been in those with all three of our insurance carriers.

Chairman TAUKE. Oh, OK.

Mr. MORGAN. This is not a small group.

Chairman TAUKE. You're not going in on just your own?

Mr. MORGAN. No.

Chairman TAUKE. You're going in in a larger group.

Mr. MORGAN. These were with large groups. All the independent employers' group, waste haulers nationwide, and now a group called IMET.

Chairman TAUKE. So, all of the employers who are small employers who are part of this group are experiencing the same kinds of premium increases that you are receiving—you are experiencing?

Mr. MORGAN. Yes.

Chairman TAUKE. Your experience is not unique.

Mr. MORGAN. No; and as I talk to other small businessowners in Iowa, they are facing the same kinds of increases—50, 60, 70, 80 percent.

Chairman TAUKE. Well, I want to again thank you very much for your testimony. We certainly appreciate it and I think all of you are evidence of the reason that we're here. [Applause.]

The next panel is the long-term care, disabled, and children panel: Julie Beckett, Nancy Klein, and Pat McCollom. I understand Julie Beckett may not be here yet, but if Nancy Klein and Pat McCollom could come forward. Julie is here.

Well, as you can see, my earlier comment was wrong. We thank all of you for coming this morning.

I just received a note that C-Span is videotaping our hearing and it will probably show nationwide at various times during the next week, so we will have more than just coverage in the room here in Iowa.

Our first witness on my list is Julie Beckett. Julie, I certainly appreciate your willingness to come here this morning. I've called on you a few other times to tell your story and I appreciate your continuing willingness to help us develop public policy in this area.

STATEMENT OF JULIE BECKETT, IOWA CITY, IA

Ms. BECKETT. Congressman Tauke, members of the Pepper Commission, I appreciate the opportunity to speak before your Commission today. Had it not been for Congressman Tauke and a few of his very influential, powerful friends and colleagues, the Katie Beckett story may have had a very different outcome.

In 1981, we were faced with no health insurance coverage, either public or private for our 3½-year-old daughter who was ventilator-dependent. Wanting to bring her home, ventilator and all, after 3 years of intensive care hospitalization, was a dream waiting to be realized. With Congressman Tauke's help, that dream became a reality, after he influenced President Reagan and Vice President Bush to allow Katie to remain on Medicaid, but be served outside an institutional setting.

Katie was the first, but for the watchful eye of Congress and the eventual cooperation of the Department of Health and Human Services, she was not the last. Today, over 100,000 individuals are home on Medicaid waivers. Unfortunately, Medicaid was not designed to serve individuals with disabilities. The restrictiveness of regulations throughout the Medicaid Program make these waivers difficult to obtain and in many cases, such as here in Iowa, it's like fitting a square peg in a round hole to get children eligible.

In the beginning of the Waiver Program, it was important to move slowly. This was new ground. I was fortunate enough to be called upon to educate individuals, parents, professionals, State and Federal agency personnel, and politicians about the needs that families have at home. I have been asked to advise many State programs on how to develop waivers and I have consequently quite a rapport with the worker bees at the Health Care Financing Administration.

Shortly after Katie came home, we saw a dramatic growth in home health care—in the home health care field, much of which was truly needed. However, entrepreneurialism being what it is, abuses became evident quickly. We have yet to identify ways to completely eliminate such abuses. However, we have at least developed some creative solutions to resolving some of these problems.

Consumer activism and education were necessary to keep people on line. Case management became a tool for access. But doing case management well means sharing the task with consumers. Case management also means educating people to access the system and reorganize the programs.

States are doing this, much of this for the younger child under Public Law 99-457 which is to our advantage. But technology-dependent children still require a great deal of time and effort. We need better case management programs and we need to empower case managers to make the decision about how the system should respond.

In the first handout that I gave you, I provided comments from the Iowa Home Care Monitoring Program which is currently serving as the case managers for the medically fragile population and children with special health care needs and their families.

The National Maternal and Child Health Resource Center, of which I am a part, is a training, information, and dissemination vehicle available for State programs for children with special health care needs and their families involved with their care. We are a kind of think tank, examining issues and attempting to come up with some solutions to problems facing children and their families today.

We are currently involved with issues surrounding case management and the financing of children's health services and family support services. We endorse the Surgeon General's national agenda calling for family-centered, community-based, coordinated care for all children.

The task force on technology of dependent children on which I served as a vice chairperson examined detail by detail ways the system would need to change to better serve children and their families while keeping a control on cost. The resource center has attempted to implement some of these changes.

Everyone agrees that the health care system needs revisions. Even those who are firmly entrenched in it would agree. The question is, how and where to start. Gentlemen, I would attest we need to start by examining that task force report. The most crucial problem we have to resolve is the financing issue. We've heard testimony after testimony of how insurance companies and HMO's have left families high and dry after promising to pay in alternative settings.

Insurance commissioners are strapped by the lack of power they possess to intervene. They can only interpret contracts. Outside of contracts, they have no control. The private sector has continually made it more and more difficult to get access to needed services. Even individualized case management programs unfortunately have become cost-containment tools, cutting back in areas that families need the most.

Hospitals, in order to capture a share of the market they are losing because of DRG's [diagnostic related groups] or managed care programs, are looking at ways to make a profit somewhere else or cost shift again to the insurer who consequently raises premiums.

In all of this mess, the consumer is left high and dry and those in most need either go without preventive care or are forced to meet poverty guidelines eligibility for Government programs, similar to the testimonies we've already heard here this morning.

The people in our Nation are doing each other in and we must understand either we pay now or we pay later and believe me, gentlemen, by avoiding the problems, the costs continue to rise. It's time for action.

Part of the task force report define three alternative ways we could use to fund a health care system for technology-dependent children. I contend we will get that system of excellence proposal. The resource center has further defined how this could be applied and I believe we should look at placing all children within this system, not just children on technology. [Applause.]

We need to better organize our system. We must have a buy-in which will produce cost-containment measures and look at both providers and suppliers of medical equipment. We must examine controlling costs on prescription drugs and durable medical equipment and seriously think about the research side of new innovative technologies and new drug therapies.

Do the American people own any share of Federal grant research and we the people say, enough is enough on rising costs. [Applause.]

Why should a ventilator from one distributor cost $6,000 and from another $10,000. Does a patient's dependence for life on a drug give the company a right to charge $98 for 300 milligrams while as soon as the market opens up to develop a similar drug, that cost drops in half?

Or the latest horror story: How can one drug that cannot cure or even prevent the dreaded AIDS virus cost $8,000 a year for one patient. Someone is making a great deal of money at the sake of the sick and dying. What has this Nation come to stand for?

Single mothers with children who are trying to earn a living to keep their families together cannot be eligible for Government support because they earn too much money, often less than $10,000 a year. They can't afford to pay health insurance premiums and some who, within their divorce decrees, the husbands, the husbands were to keep the children on their health insurance policies. Providers refuse to treat the children because the parent who carries the insurance is not there in time of accident or injury or even worse, the father does not follow that divorce decree and never provides health insurance coverage.

Children need mandated access to insurance benefits whether through public or private sector. Maybe we should consider children as a separate category; provide insurance perhaps through school district and then mandate employers to provide insurance for the rest of their employees, or the rest of the people they've employed.

This would get people off welfare roles, reduce the problems of employers trying to cover all of the family under their group policies. Children as a group would spread the risk across well child and special needs care so insurers could compete for providing the best for the least.

A better organization of services would also be helpful for everyone. This would also support the community-based concept needed by both rural and urban families. Currently, there are citizens in the State of Iowa who must travel anywhere from 6 to 8 hours to get to needed medical care for their children. They are apt to do this at least three and four times a year. No transportation cost covered; no provision for helping them stay within that area and the provision that's provided is the free service that they may get within that medical institution, oftentimes not by a primary caregiver.

Again, gentlemen, we need to look at revising the entire system, not just piecemeal solutions which only provide a further fragmentation of an already complex system. Families can no longer afford to pay $500, $600, $700, even $1,300 a month in health insurance premiums which cover only a portion of their health care costs.

Families do not want to feed on the system, but they are being forced to quit their job, sell their worldly possessions, live on food stamps and AFDC [Aid to Families With Dependent Children] payments just so they can get health insurance benefits through the Medicaid Program which may not provide everything they need.

Paul Pietzsch mentioned this morning about the diversity in the Medicaid Programs across the United States. It's appalling, some of the things that they are lacking.

Catastrophic illness has been the growing American tragedy. It started with catastrophic illness; it's now affecting everyone.

Before I conclude, I would also like to bring to note an article that appeared in the Woman's World Weekly—this is a supermarket magazine type thing—that talked about why 12 million of our children can't afford to get sick. Now, this is an article that many people would just pick up and read.

There were three associations that were mentioned at the end of the article: The National Maternal and Child Health Resource Center just happened to be one of them. The title was, Where To Go For Help If You Are Uninsured. Unfortunately, people thought maybe we'd be able to provide them insurance or at least pay for something they needed with regard to health care.

It evolved such an onslaught of phone calls that we are preparing right now the data on those phone calls. These are families responding to other families and it's surprising the number of individuals and the types of phone calls we received.

Oftentimes, many of these families were covered by Government programs that just couldn't provide everything and it was really sad. The testimony about single parents with children and the problems with divorced parents, that was probably the strongest kind of cry we got from the National Maternal and Child Health Resource Center.

And it's really frightening to know what these families are facing because when children get sick, they get sick very quickly; they get seriously ill and oftentimes they are not, it's not difficult

to treat them and they are out of the problem. If they don't receive the treatment, it's the secondary and tertiary area handicapping conditions that start to promulgate, that we continue to pay for with catastrophic health care costs.

The other thing that I have provided you with is the National Parent Coalition to Improve Health Care Financing for Children With Special Health Care Needs statement. It just talks about the fact that families of children with special health care needs have a very unique aspect at viewing the health care system because we must interact with it on a daily basis and we just request that any kind of testimony that you gather that you are looking at parents and families for that kind of aspect.

Thank you very much. [Applause.]

Chairman TAUKE. We have a copy of another statement. We aren't sure what that is.

Ms. BECKETT. I'm sorry. That's the system's proposal, or systems of excellence proposal that we enforce from the task force. The Resource Center has previously defined some of the things that should be a part of that system.

As you will note, we asked for a demonstration project to be utilized around the United States, maybe four or five States can attempt something like that. It's a radical proposal to pull all children out of the current insurance problems and Medicaid problems and start funding them with a total program. But I think in the long run, it will serve as a solution to many problems we are facing right now.

But we've begun to reiterate what Governor Ray said and the panel—in the last panel. We need to really look at how to get control of provider costs.

Right now, the average physician's income per year is $150,000. You know, there are families in this country that are living on less than $8,000 and it's a crime.

And in this State, we are well taken care under the Medicaid Program compared to some of the States in this Union and it's just so sad to see what's happening to these children and their families.

The other side of it is, we ally with many of the concerns of the elderly at this point—families with children with special health care needs because we encounter many of the same kinds of battles. But I think we also have to look at the fact that these families are oftentimes young families. They are facing the rest of their lives.

The mother in Maryland gave testimony before Congressman Pepper 2 years ago and talked about how her family still owed $800,000 to the Children's Hospital National Medical Center which, you know, they'll never be able to pay off. To know that you're facing that debt for the rest of your life is difficult for some of these families.

I know that Nancy's next and actually, Nancy's child, Jennie, was the first child covered under the Waiver Program here in Iowa. Katie has an exception policy, which, thank heavens, we have Congressman Tauke and she was able to get and because of that, Nancy's daughter is on the Waiver Program. But even her story is devastating—what she's currently going through.

Chairman TAUKE. Nancy, that's an appropriate introduction for you.

STATEMENT OF NANCY KLEIN, CORYDON, IA

Ms. KLEIN. Good morning. My name is Nancy Klein and live in Corydon, IA, with my three children. My daughter, Jodi, is physically and mentally disabled and requires constant care. Jodi is on continuous oxygen. She has a gastrostomy, or a tube in her stomach because she cannot swallow and she is on an apnea monitor to detect stoppage of breathing. Jodi also needs about six medications to keep her going. This could be your child.

In 1986, I became a widow. Up until that time, our family had coverage under my insurance employer, Blue Cross and Blue Shield. The monthly premium was $159 a month. Soon after my husband passed away, my—the former employer wanted to switch companies—I continued coverage under this even after my husband died.

And the reason they wanted to switch was because of Jodi—because of the rising cost that Jodi had. What eventually happened was that the company decided to go to a new group policy that was cheaper, but would not cover Jodi and I was dropped from the policy when they found out that I could be covered under, under my own policy, under Blue Cross and Blue Shield. That was in November 1986 and it cost me $245 a month in November.

In September 1986, I placed Jodi in a convalescent home for children, but continued to keep her on my insurance policy, thinking that I could bring her home. And in November of that year, she spent the month in a Des Moines hospital having her right mastoid removed. In April 1987, she was put in the hospital again because of complications of a respiratory problem where she almost died. Then later that month, they removed her left mastoid. Then I brought her home. Although she had only been in the convalescent home 3 months, I decided to bring her home at that time. I felt that her health problems required constant care—constant attention and the one-on-one care needed to be provided at home.

Jodi came home in May 1987 and she is now on the model waiver which provided title 19 assistance and helps pay bills Blue Cross and Blue Shield does not pay. Model waiver only pays for 8 hours of care for 5 days a month and Blue Cross and Blue Shield pays for 15 hours of nursing care every day for 7 days a week until our limit runs out.

In January 1988 my insurance premium went up to $530.50 a month, a 30-percent jump from the year before. I couldn't believe it, but when I contacted the commissioner of insurance, William Hager, he assured me that it was true and even legal. Also, Blue Cross and Blue Shield informed me that my limit would be $250,000. Jodi's many health care needs and expenses means that this may happen within a year and then I don't know what we will do. I'm hoping to sell my house and move to a place where I can get a job to care for this problem. I just completed a year of college and I have my house up for sale and hoping to move to Des Moines to get a cheaper group policy under an employer.

If I didn't have any insurance, the model waiver may possibly provide 40 hours a week of home care, but would only pay about 80 percent of the cost. My only option may be to put her in another institution, but I am afraid she may not get the quality care she needs. Also, the county would pay for her expenses.

While it is not easy taking care of a severely disabled family member at home, it is important. I don't know what I'll do if I don't find a job with health care coverage before Jodi reaches the maximum on our Blue Cross and Blue Shield. I think about it every day and believe that for my family and others like it, we must have a National Health Insurance Program that works for everyone. [Applause.]

Chairman TAUKE. Thank you, Nancy.

Our next witness is Patty McCollom who is representing the Iowa Head Injury Association. Patty, thank you for joining us.

STATEMENT OF PATRICIA McCOLLOM, ON BEHALF OF THE IOWA HEAD INJURY ASSOCIATION

Ms. MCCOLLOM. Thank you. Congressman Tauke, members of the Pepper Commission, my name is Patricia McCollom. I have a master's degree in rehabilitation and I am a registered nurse, practicing as a rehabilitation nurse in the community. I am a certified rehabilitation registered nurse with over 20 years experience and a certified insurance rehabilitation specialist. At present, I am owner, president, and senior rehabilitation consultant for Management Consulting & Rehabilitation Services, Inc., Ankeny, IA. Our firm exists to assist the disabled in the community, with coordination of resources and return to work, when possible, within permanent disabling limitations.

Thank you for the opportunity to address concerns and issues relating to the needs of long-term care and availability of resources for the brain-injured individuals on behalf of the Iowa Head Injury Association.

Rehabilitation, in total, is a fragmented part of the current health care system. Rehabilitation itself is poorly understood by health care professionals and the public; policies for services and rehabilitation financing are underdeveloped. In perhaps no other health sphere are collaborative efforts more needed among providers, purchasers, insurers, consumers, and government at all levels, than with rehabilitation of the brain-injured individual.

The National Head Injury Association reports that every 15 seconds someone receives a head injury in the United States, resulting in 70,000 to 90,000 survivors with lifelong disability. In Iowa, research demonstrated 10,000 diagnoses of head injury between September 1—or, excuse me, July 1, 1987, and July 1, 1988.

Due to technological advances in medicine, lives are saved when even 5 years ago those same lives were lost. Though medical technology has advanced, communities, providers, insurers, and government programs have not kept pace with the long-term and permanent needs of those who survive head injury.

Head injury is forever. The resulting disability may be obvious if the part of the brain damaged involves control of motor function of the body. But, more tragically, head injuries cause behavioral and

cognitive changes, which alienate the brain-injured individual from their family, their work, and their community. A brain-injured individual may experience errors in judgment, reduced concentration levels, reduced insight, reduced decisionmaking skills, loss of appropriate self-care skills, and social skills. After acute medical care is completed, the brain-injured person returns home to find he or she can no longer participate in activities that were routine and there is nowhere to go for help. One of my brain-injured clients explained the feeling in this way: "I didn't want to be in a car accident, but it happened. Before I hit my head, I was a person. Now I must write everything down, but cannot remember what it means when I try to read it. I used to work 10 hours a day, but now I get so tired trying to be organized, I get nothing done. I used to play with my children, but now I don't remember the rules of the game. There is no place for me and no one understands."

The financial consequences of head injury are enormous. The National Head Injury Insurance Committee, in a September 1988 report, published an illustration of rehabilitation costs and norms for service.

For acute medical care after head injury, the average length of stay is 60 to 90 days. The average cost per day is $2,000 per day. With an average of 75 days hospitalization, that is $150,000 for acute care.

For acute rehabilitation cost, the average length of stay is 90 to 120 days. The average cost per day is $550 to $600. The total $60,365.

For extended rehabilitation or postacute head injury, the average length of stay is 15 months. The average cost per month is $13,000. And I would add, in my research, I have found the cost for postacute head injury treatment ranging from $8,000 to $32,000 per month across this country. The total for postacute head injury rehabilitation, $195,000.

If a residential program for the remainder of the life of the individual is required, the average cost per year is $60,000 to $125,000, or a total lifetime average of $4,567,875.

This outline of rehabilitation services and costs represents appropriate care when funding exists. My experience clearly shows that few brain-injured persons receive care identified in this outline.

Insurance funding as it relates to trauma, is usually predicated on how the accident occurred. The mechanism could be an automobile, a fall, a gunshot wound, a blow to the head at the worksite, a sports injury, child abuse, or a victim of a violent crime. The damage to the brain in all of these situations may be severe. Yet the question of who gets services and for how long may be quite different, based upon the type of insurance system involved.

Workers' compensation insurance, required throughout the country, provides for medical care to promote the maximum medical recovery and highest functional possible outcome for the individual. In my company, we believe that those who have experienced head injury at work have the most opportunity for appropriate care, since medical and rehabilitation services are mandated by law.

Group health insurance most often is purchased by an employer as a benefit and provides payment for health care at a rate representing the levels of risk and cost an employer is willing to assume.

Limits for payments are established with the contract and do not even begin to approach the cost of head injury treatment.

Because of misunderstanding of brain injury and the treatments which promote independence for the brain-injured—cognitive therapy, a structured environment, individualized strategy development for memory and behavioral change, counseling—the insurance or government program available do not fund care.

This failure to fund necessary care occurs for other reasons as well. Head injury is not recognized as a specific diagnostic category which creates obstacles in reimbursement for care. Some health policies limit treatment to certain types of rehabilitation, particularly physical therapy or occupational therapy.

Some health policies do not recognize community reentry program for social and cognitive skill development of eligible coverages. Brain-injured individuals are classified for governmental programs with the mentally retarded and developmentally disabled, when, in fact, the brain-injured individual gains in independent living, social skills, and vocations skills with appropriate treatment.

Coverage is most often not available for maintenance care in the home of brain-injured individuals with judgment problems and cognitive and behavior problems, sequelae of brain injury, are frequently classified as mental or nervous conditions and, therefore, excluded under most health care coverages.

Gains in brain injury rehabilitation occur more slowly and, therefore, they exceed the approved length of stay limits which is a common health care cost-containment strategy.

As the population of brain-injured citizens increases in Iowa and the United States, it is critical that access to appropriate care for these individuals is assured.

I believe that traumatic brain injury must be established as a category in reporting systems to ensure identification and epidemiological assessment for survivors, to document this diagnosis as an area for research and training, to allow accurate assessment of insurance needs which does not exist at this time, and to provide a basis for government resource allocation.

The government and private sector must unite to develop overall planning and coordination for brain injury service and research, and to promote leadership in an area of the health care delivery system, which has been sorely lacking to date.

Brain-injured individuals must be treated through community-based, comprehensive programs, not warehoused in care facilities where no opportunities for gain exist. Until access to care is achieved [applause] until access to care is achieved, our brain-injured population has been saved, but for what? Today, the majority of the brain-injured are lost survivors. [Applause.]

Chairman TAUKE. This has been a most thought-provoking panel. Julie Beckett, if I could begin with you—I shouldn't perhaps put you on the spot like this, but I'm certain many of those who are listening to the testimony that you offered and the testimony that came from Debbie Gansemer wonder why is it that the Gansemers face the kind of problem with Medicaid that they do. Why do they have to live within those Medicaid limits when, let's say, in your

case, with Katie, those same limits weren't applied to you and your family. Can you explain that?

Ms. BECKETT. Well, at the time, Katie was 16 to 18 hours on a ventilator, receiving gastrostomy feedings three and four times a day and needed constant watching basically, not constant care, but constant watching. There were physical therapy, speech therapy, many of the kinds of things that Katie would require—chest percussion treatments, et cetera.

At the time that we received the Medicaid exception of policy, Katie was receiving intensive care and was costing the Government $15,000 to $18,000 a month. But we proposed we could do Katie's care at home for between $2,000 and $3,000 a month, which meant providing just absolutely the minimal amount of kinds of needed services that Katie would need. In particular, it meant paying for the ventilator, the air compressor, the supplies that she would need. We did not have any nursing care when Katie came home. We did not ask for any respite care of any kind. After all, we'd been 3 years in a hospital. We'd just as soon stay home for a while. So that worked to our advantage.

Unfortunately, many other children are not in that kind of state. The Gansemers, for instance, have, as they said, a healthy child with cerebral palsy. It's as if every child with any kind of disability now, insurance companies refuse to cover much on and are scared to death to even pick them up because if they do end up in the hospital, they have to—they do require some extra kinds of care.

When Katie came home, that kind of cost savings was very dramatic. Now that home health care costs have kind of leveled off—when Katie came home, there was no home health care agencies in the city of Cedar Rapids. If you can imagine. Not one. There were—the gentleman that served our family in particular came from Waterloo, which was 60, 70 miles away at the time, without 380 and so it was a fairly difficult process. Now you find home health care agencies almost every other block at this point.

And because of that growth, they are able, you know, the cost is going up in home health care as well as in hospital care. So, it's equaling itself out and it's kind of scary because no parameters, no limits have been put on rider costs.

As far as the Gansemers are concerned, Federal poverty guidelines are still the way that supplemental security income provides access to children with disabilities and those Federal poverty guidelines restrict access then in the State of Iowa to Medicaid for those particular families. The family's income counts; nothing to do with the child themselves. The child is deemed down a part of that income and therefore is eliminated on that. So the family can't do anything [applause] to fight this kind of problem and it's not just income eligibility, it's also resource eligibility. So they also can't own anything. If they own their land, if they own any farm equipment, for instance—if they own a car that's worth a certain value amount—anything—they are automatically eliminated. And if they have no insurance, then they must meet that because they have no other way to access any kind of health care for their child with cerebral palsy, for crying out loud. That's in a minimal disability. You know, for this particular child we're talking about, health care needs are minimal. And it's a crime.

So, it's sad where, you know, they are forced to do that or they don't get preventive care, which means that the child has further disabling conditions which quadruple the problem and then health care costs rise.

We have families, for instance, in the State of Iowa that are waiting to get a child braces, waiting to get a child—even surgeries, you know, that can be planned surgeries—they wait until they know they are going to be eligible. I mean, that's a crime when a child's in pain to put off all of this, but that's the choice that families have in this country and it's sad to say that that's true.

Under the Waiver Program, 100,000 individuals, not only children, are eligible under this program that waives the parent income and allows the child to get needed care. However, they must meet a level of care that would require some cost-effective measures which mean, it would be cost-effective.

Plus, the child would have to be institutionalized. In the State of Iowa right now, there still is not an institution other than hospital care that could take care of Katie because she's still ventilator-dependent. She's not on 16 to 18 hours a day, but there is no one else and it's a crime that she has to go to an intensive care unit every time that there's a problem.

There are very few options in this country for these kids and for the Gansemer's child. They must, in fact, meet those kinds of guidelines.

Chairman TAUKE. You indicated in your comments that you felt we needed to revise the entire system.

Ms. BECKETT. Yes. [Applause.]

I don't think I'm alone in that at all. Many individuals do feel that way.

Chairman TAUKE. I guess I just wanted to say, you aren't alone because there is at least one Congressman that thinks the same.

Ms. BECKETT. Yes.

Chairman TAUKE. One of the things I think that has become clear in this Commission as we've looked at the issue of long-term care and the issue of health care for the uninsured and underinsured is that, in order to deal with those two problems, you do have to revise the entire health care insurance and health care delivery system in the country because otherwise, as some of our earlier witnesses have said, you just kind of push on one thing to cause all kinds of other problems. So we do need major overhaul.

Ms. BECKETT. We just finished at the National Maternal and Child Health Resource Center what we call a health care financing guide for families. And that, basically, gives families at least an opportunity to look at where they might be able to look for funding to get certain services covered. Plus, it provides some defense mechanisms like questioning your private insurers about what, in fact, your contract does hold.

One of the problems with children is—I don't know why people think that we go out and purchase insurance after we have children with special health care needs. We don't—we aren't able to do that. The child is born into their contract and you must work within that contract to try to maintain every dollar amount you possibly can.

Katie had used up a $1 million policy in less than 2 years and this was in 1978-79. And that's frightening to know that a child like that is costing, you know, five times that much probably today.

The other—if I could just take 1 more minute. We have been working on a case—I work on a one-to-one basis with families. We have been working on a case that's really a typical scenario for what is occurring in this country. There is a family of four. The father works for a small employer, 35 employees within this company. He's a wonderful engineer. The child has some severe problems; was born prematurely for no particular reason—has some significant disabilities; spent 22 months in hospital ICU [intensive care unit] care. The insurance company person said: "It's really costing us a lot of money, can't we transfer him home to an alternate setting?" They said: "Are you kidding, we'd love to go home." So, in fact, that's what they did.

The insurance company, 2 months later, sent them a notice that they were not only dropping that particular child and family from that policy, they were dropping the entire company. So 35 families are now going to be uninsured.

The employer who was very similar to Mr. Morgan, a wonderful man, trying to do something right in this country, was attempting to look for other insurers to cover him. No health insurance coverage could be provided to this company with 35 good employees as well as this family with one child. And they could get nothing because they were afraid that they would have to take this child and cover him.

They would only do it if they could get Medicaid to cover that particular child. So we've worked to see—that's how I was approached, because of the Waiver Programs, that I work with them.

This particular State does not waive even parental income in institution, so the family has to get down to poverty level before they're even served in institutions. So, this particular—this State couldn't show cost effectiveness, the Federal Government could not grant them a waiver; there was nothing. We have gone through every step—the Governor's office intervened; everybody intervened.

It turned out that we had to go to the Vice President of the United States. Who then went to the Secretary of Health and Human Services where hopefully, we will be able to get this child a waiver to take care of this child so that the other 35 families don't have to face uninsurability.

It's frightening to know that we have to do that kind of juggling. Now, why does it take two advocates—the Governor's office, hundreds of people in Medicaid, the Secretary and Vice President of the United States to do what was supposed to be done in the first place for this particular child. It's a tragedy and that's a typical scenario. That is not the unusual. That's what's happening all over this country. And the child is 24 months old; 24 months and he's facing the rest of his life.

Not only that, but the 9-year-old that they have—what the father is looking at is, he will never be able to go to college. The father called me on the phone and I said, next time I'll call you back because I have a WATS line I can use, and he said, either the Government's going to take it or AT&T can have it.

And it was so frustrating to know that that father has lived through 7 months of not knowing where life is going to be in the next 2 days because every month it was like, "we're going to drop you this month; no, we're going to drop you this month." Finally, the Governor's office was able to waylay the insurance company by kind of putting the Civil Rights Commission on top of all these things. You know, you can't just drop this child.

But they really have no alternative. That's frustrating.

Chairman TAUKE. Nancy, did I understand correctly in your situation, that if you chose to institutionalize your child that then you would be able to have some of your problems resolved, but, in part, I mean, because you want to take care of your child, that you're facing all of these problems? Is that a correct understanding?

Ms. KLEIN. Yes. She probably wouldn't live if she was in an institution. She spent 3 months there and almost died. Not that they didn't take good care of her, but it wasn't the quality care she got at home.

Chairman TAUKE. Well, I just want to express a commendation of a lot of people who are here for that commitment, and courageous commitment on your part.

Patty, you indicated that the cost of—if I understood correctly, the cost of providing services to a head-injured patient—a typical head-injured patient—is about $4½ million for a lifetime average.

Ms. MCCOLLOM. That is correct.

Chairman TAUKE. That is a staggering sum of money obviously. In your testimony, you didn't really, at least as I understood it, tell us in what direction we should head in terms of trying to figure out how to deal with that problem. I mean, I can certainly understand the problems of a private insurance company taking on that kind of responsibility. Where should we look in order to meet this need?

Ms. MCCOLLOM. I tried to suggest in a comment relating to a public and private task force, if you will, to look at the problems and to develop leadership in this area. I think that is the way to go.

I can give you a very specific example. There's a group here in central Iowa called OL, On Life, which has been developed out of the need for having some sort of a long-term program for the head-injured and parents, actually, from the Head Injury Association, developed this particular separate entity, OL. And we are in the process of just going out, attempting to gather funds. We do have a significant contribution and support from the community and from private industry as well and we are trying to gather support from the State and from the county and we have not been successful to date in doing that.

In fact, last week, the Economic Development Commission turned us down for funding because they felt that this was not an economic development situation and it was a great blow to us on the program.

What this is is a nonprofit, long-term care facility for the head injury and there are a number of people, highly qualified individuals who are lined up to work in the program. It's a beautiful example of how public and private could work together and we only hope that we can continue in—and begin our building in October.

Chairman TAUKE. And so, that would provide not only proper care, but at a reduced cost is what you are suggesting?

Ms. MCCOLLOM. That's correct. The cost is one-half to one-third of what it is in the proprietary programs. You see, I laughed at your comments about entrepreneurial behavior because certainly the head-injured began to survive; it became increasingly apparent that there were no resources for them and so many people who were working in private facilities began to get the idea that they could do it better outside of the private facilities and it's challenged the proprietary systems. And there are a number of very high quality in proprietary head injury treatment programs. Most of them are on the west coast and on the east coast. However, the costs are phenomenal and we need to look at ways such as this OL Program which can deal with the issue of the long-term care, but also deal with the issue of the extreme cost.

Chairman TAUKE. Ed, do you have any questions?

Mr. HOWARD. Ms. McCollom, is it fair to say you would say a different kind of services, a different bundle of services are needed for people with brain injuries than would be needed, say, for a frail, elderly person with some sort of cognitive difficulty.

Ms. MCCOLLOM. Absolutely because with head injury, every head-injured individual is different. Two people can be hit in the same place on the head and the resulting sequelae would be different. We need to look at each individual; we need to look at structured environment; we need to develop programs that are individualized according to whatever their pre-more—or greater pre-injury history was.

And we can see gains. In the literature, there are thousands of stories that people have had head injuries, came back, were able to return to work, were able to develop other sections of their brain, if you will, to carry on with quality life.

There are some that we make no difference with, the permanent vegetative state, for example. And even the long-term care necessary for those individuals is very difficult to get quality care. But for those who have potential to return to a community, to return to their family, return to work, we just don't have the resources available so all the access care is greater than any of the national committees that have addressed that, really, really, truly have come out and said: "I've read all of those reports, I think it's far greater than you have indicated."

Chairman TAUKE. And your statement talks about upward of 70,000 people a year being added to the roles of those with head injuries. Do you have some notion of what the overall total is today?

Ms. MCCOLLOM. Well, in Iowa, we are saying that there are over 1,000 who really could use these services. In my office alone I have enough clients with severe head injury that I could keep the OL Program full for 5 years. They have 22 beds that will help them improve through certificate of need.

However, I really can't give you a specific statistic. I believe the Head Injury Association said it's over 2 million. And that may be way low—I'm sorry.

Chairman TAUKE. Thank you. I want to thank all of our witnesses for your very revealing testimony this morning. [Applause.]

Our next panel is a panel on long-term care for the elderly and the panel is Betty Grandquist, Kathy Vermeer, and Maury Hunter.

Our first witness on this panel is Betty Grandquist who is the executive director of the Iowa Department of Elder Affairs. Welcome, Betty.

STATEMENT OF BETTY GRANDQUIST, EXECUTIVE DIRECTOR, IOWA DEPARTMENT OF ELDER AFFAIRS

Ms. GRANDQUIST. Ladies and gentlemen, I'm really, really pleased to be invited to speak here today for more than one reason. I have things I want to say, but the things that I have learned listening have been very beneficial to me. One of things that I think comes through loud and strong where everyone here is considered, what their great need is, is for home- and community-based services and second, that these have to be on a one by one basis looked at. We have to have a system that revolves a person's needs, not by the system into an already existing cluster of needs.

I speak particularly to needs of older people and as you mentioned, Congressman Tauke, we've been sort of ahead of the rest of the Nation in Iowa because we've had an older population longer than most of the other States have. We found out some things. We know, among other things, that only about 1 percent of people 65 to 74 will be in an institution. About 6 percent of those 75 to 84 will need to be in an institution or nursing home. Then you get to 85 and over and that will go to about 22 percent. And, of course, that's very significant for Iowa because we do have a high percentage of those 85 and over.

Another interesting statistic that I think is that in Iowa we have around 560 people over the age of 100 and out of those, 20 percent are not in an institution. In other words, we have that many people over the age of 100 that are either living, in some cases, by themselves; in other cases, with family. They're able to do that because of the tremendous community support that they have. I think that says a lot for our State.

When we look at needs of older people who need long-term care, we want to remember one thing, that, as we get older, health care lying between sick and well blurs a great deal. We may be sick in one part of our body and not in the other part of our body. That's when community-based care can be so very important because we can still do many of the things that we've done and we have a little help. That help may be medical in nature, but it's more likely to be personal care of some kind, such as adult day care services, such as someone to help shovel walks, to keep the house in repair for an older person to live in, someone to help with meals.

Those sorts of things become much more important. That's why we see the need for the system to not concentrate on medical needs, but on some of those homemade and personal-type care needs.

When we look at the reasons people are in nursing homes, we find out that they usually have several chronic conditions. Two-thirds are admitted directly from a hospital. The people in nursing homes are 10 times as likely to be widowed, divorced, separated, or never married. I think that's a very important fact because it tells

us that many, many people are in nursing homes because they can't get the help for personal services at home.

They're likely to have reduction in informal care available and in Iowa that means, for many of us, the kids have moved to the coast. The kids aren't real close anymore to help them. Now, that doesn't mean the kids aren't interested because we get calls in the office all the time that: "I'm worried about mom; I'm worried about dad; I think they need a little help, what can we do about that?" But they aren't right there to do it, so we have to have systems that somehow people can come in and help with that.

In nursing homes, 50 to 60 percent suffer from dementia, such as Alzheimer's disease. We do know, as we get older, that the incidence of Alzheimer's is greater and I think Maury Hunter will give you some very good testimony to the effects of that.

Half of the people in nursing homes cannot see well enough to read the paper. One-third cannot move around on their own and one-third are incontinent. Those are conditions that are not something that must say, you must be in a nursing home. If there is the proper support and help in the community, those types of things can be taken care of at home.

Home- and community-based services are characterized by the following: They provide mostly nonmedical, personal care services and I think that as our population gets greater, the thing we remember about health care is that if the part that's medical lessens, and the part that requires help for chronic conditions increases, the opportunity to that is that we could—that could be furnished by people without the highly paid expertise that's needed for medical care many times.

Home-based and community-based services cover a wide range of possible assistance, including meal service, homemaker service, minor housing modifications—very important for people with disability—how their housing is adapted to them, and emergency response systems. We have many instances of people well into their nineties in Iowa who stay by themselves because they have the emergency response system connected to a hospital. If they fail to report in in the morning, then someone checks on them.

The housing services include the following alternatives: accorded care homes, which in Iowa is called residential care facilities; adult foster care, which here we call supportive care as a rule, the—those are homes where people don't need medical help, but maybe three to five younger people will stay in this home and just have someone to help them with their transportation, et cetera; and congregate housing, that is apartment-style living with supportive services, especially meal services.

Those are some of the things that we are looking at in Iowa and working very well. We have designed some other innovative approaches. We have six pilot projects for community care for older people, particularly the frail elderly and one of our projects in Sarasota County won a national award for community achievement. We've gone at this a little differently than some of the States have when they talk about peak management. We've selected our area agencies on aging because they do not provide services. They're a disinterested party as far as what kind of service is provided.

To facilitate the regular service providers and case managers to come together and develop an individualized package of care for the frail, elder person involved such people as the community not only as the traditional caregivers, such as homemaker, home health, public health nurses, mental health services, substance abuse services, and in some instances, the policemen have asked to be part of that because they want to know more and have access to fighting health for older people who need the help with multiple problems.

I think that's all I want to say right at this time because I know that we have some very eloquent testimony from our other two panelists here. Thank you.

Chairman TAUKE. Thank you, very much, Betty.

Our next witness is Kathy Vermeer from Davenport. Kathy, thank you for joining us this morning.

STATEMENT OF KATHY VERMEER, DAVENPORT, IA

Mrs. VERMEER. My name is Kathy Vermeer and I live on a rural, west-end acreage in Davenport, IA. I'm 41 years old, married, and the mother of four children, ranging in ages 11 to 22 years old. The three older children are full-time college students, live outside the home, and they are almost totally financially supported by us. Our 11-year-old son is a student in a parochial grade school. My husband, Richard, is the director of emergency services at an area hospital, working 12-hour shifts, both days and nights, averaging 240 hours per month. He is also the medical director of Medic, the Davenport hospital-based ambulance service. His administrative and supervisory duties required of these two positions plus committee meetings add additional hours to an already hectic schedule. After meeting these obligations, he begins still another job assisting me with the care of my mother.

I am a registered nurse with 15 years experience in nursing homes, critical care units, emergency departments, and most recently, long-term home health care, which I provide for my 81-year-old mother, Jennie Kessler.

My mother's medical history and ensuing health care requirements are of an evolutionary nature, not unlike many of her peers. For more than 10 years my older sister and I watched our mother enter into a downward spiral of mental and physical deterioration. Her eyesight was becoming compromised by glaucoma, compounding her confusion and adding to it the risk of falling. Two types of eye drops were prescribed; one to be installed in each eye twice a day, the other four times a day. My mother was unable to administer the drops herself and my repeated attempts to teach her proved to be unsuccessful as well.

The distance between my mother's home in Bettendorf and my home, plus the care of our still young son prevented me, as my sister's work prevented her, from carrying out this treatment with any regularity. We contacted the VNA [Visiting Nurses Association] and explained the situation. But due to my mother's Social Security income level, a charge of $20 per visit would be assessed for the services of a nurse to instill eye drops. Her income was above the limits under which such services would be covered by

Medicare, yet the $80 per day out-of-pocket fee was well beyond her financial reach. Even then the existing system failed to meet my mother's needs. She had fallen into a chasm perpetuated by a health care system willing to help only those that were deemed impoverished.

Coveting her independence, my mother rejected my invitation to live with me and my family, and instead opted for a condominium in the same building in which my sister was living. What had been a bad situation was rapidly becoming worse in unfamiliar surroundings. Her health was being jeopardized by her inability to cope with everyday life. At that point, she was truly a candidate for home health care services, but her income and an unacceptable diagnosis once again prevented her from accessing the system. She couldn't afford to pay for the care, yet she did not qualify for Medicare assistance.

Many patients have fallen into this state of limbo until a recognized health crisis occurs, such as stroke, requiring immediate intervention. Overnight decisions are made by distraught family members and, when counseled concerning options for long-term care, they are offered the only one available—nursing homes. My husband and I had already agreed to save my mother from institutional extinction should such a crisis occur. But we still had hopes of sharing our family life with her before that eventuality, and while she could still enjoy it. We finally convinced my mother to move in with us 5 years ago.

At that time, my mother needed help with most of her personal care, but maintained some independence in walking and eating. She attended adult day care twice a week for socialization with people more her age. Due to its first floor convenience, my husband and I relinquished our master bedroom to my mother in the hopes of recouping other permanent quarters for ourselves at a later date. But as my mother's health care needs escalated, the idea of a room of our own dimmed, and at this date we are still nomads in our own home. During the summer and fall of 1986 she suffered a cracked pelvis followed by a broken wrist, both resulting from falls that underscored her increasing difficulty with simple unassisted movements and orientation. A routine scan during hospital convalescence confirmed a stroke which had occurred sometime prior to her first fall. Her mental acuity continued to decline, and she experienced marked personality changes punctuated by recurrent periods of inconsolable anxiety. This was presumed to be the sequela of a second "silent" stroke. She could no longer walk unassisted and could never be left alone.

In January 1987 she suffered a third stroke, rendering her completely disabled and bedridden. She presently requires total skilled nursing care, of which I am the primary provider. Just the physical demands for this type of care, given by one person, during an 18-hour day, are exhausting. My mother needs to be turned to alternate side and repositioned every 2 hours to prevent decubitus ulcer or "bedsores." In most cases these ulcers are preventable by good hygiene and strict adherence to a repositioning timetable. My mother has never had a bedsore, yet they are commonplace in many so-called skilled nursing facilities and nursing homes. A once-a-day visit to a bed-bound patient by a home health aid, re-

gardless of his or her diligent efforts, will not prevent these painful ulcers. These frequent movements also help to promote the health of the lungs and could prevent certain types of pneumonia.

Due to an impaired swallowing reflex, my mother requires—my mother needs frequent oral suctioning. More than once she has aspirated secretions into her lungs, causing a virulent case of pneumonia. The last two bouts of pneumonia this past spring were successfully treated at home, avoiding the most costly hospital stays. However, due to the lack of coverage for home treatment, her expensive drugs were not covered by Medicare.

Unfortunately, the unavoidable aggressive antibiotic therapy for her most recent pneumonia precipitated pseudo-membranous colitis of a 2-month duration, treatable only with an even more expensive antibiotic, Vancocin. A 10-day supply of Vancocin, the drug of choice, cost $170. Another 6 days of the drug was needed at the cost of an additional $102.60.

Although my mother more than met the criteria for hospitalization, we maintained her at home. But once again we were penalized rather than rewarded for saving the Government the cost of another hospitalization. The price of my mother's medications from January 1, 1989, through July 24, 1989, totaled $3,784.56. Only $500 is reimbursable annually by her private insurance company, leaving her total out-of-pocket expense to date at $3,284.56. We can anticipate at least another $3,000 worth of noncovered prescription drugs for the remainder of 1989.

My mother's bladder is perpetually drained by a Foley catheter. Patients with indwelling catheters are prone to recurrent urinary tract infections. Periodic replacement is suggested every 2 months, and is a sterile procedure that should be performed by skilled nursing personnel.

In an attempt to address the nutritional needs of my mother, two unsuccessful surgeries were performed; one for gastrostomy and one for jejunostomy. She is currently medicated and formula fed directly into her small intestines by a system of dual tubes, one within the other, utilizing the gastrostomy, or the external opening into the stomach, as both entry and anchor point for these tubes. Simple gastrostomy tubes can be replaced in the home. This must be done when the water-filled balloon, which maintains tube placement in the stomach, either ruptures or begins to leak, allowing the escape of gastric contents.

My mother's secretions are so caustic that they have caused first and second degree burns, not only around the tube, but covering her stomach, chest wall, and arm. It is treated as a chemical burn and requires up to 2 weeks of diligent care for complete healing. These secretions periodically back up into her esophagus, causing ulcerations, nausea, and discomfort. Simple 4 by 4 dressing around the stoma are changed two to five times daily to prevent skin breakdown from seepage. Conventional and costly stoma supplies were tried, but proved ineffective. Barrier ointments and salves used under the dressings for skin maintenance range from antifungals to zinc oxide preparations.

Due to the idiosyncratic nature of my mother's feeding system, tube replacement, until recently, has always required hospital outpatient services and endoscopy performed by the specialist familiar

with my mother's remarkable medical history. My husband, after conferring with this specialist, devised a method for home tube replacement, saving the Government thousands of dollars a year previously spent on this procedure. Although his intent for devising such a system primarily for my mother's well-being and comfort, the Government benefits financially as well. And although our combined training, ingenuity, and dedication for providing long-term care for my mother has eased the financial burden of our Government's present health care budget, we are not able to declare my mother as a dependent or a tax deduction.

Our present health care policy and private insurance companies weigh the overwhelming benefits on the side of institutions and slight those individuals, such as myself, a long-term home health care provider. Advances in medicine have enabled us to save a life that might have been lost. But what has been forgotten are the needs involved in living that life out to its fullest. The life saved in the hospitals today will be lost and forgotten by the existing system tomorrow. [Applause.]

Chairman TAUKE. Thank you very much.

Our next witness in this panel is Maury Hunter from Des Moines. Welcome, Maury.

STATEMENT OF MAURY HUNTER, DES MOINES, IA

Mr. HUNTER. Greetings. Yes, I'm Maury Hunter. I am the owner/operator of a small business here in Des Moines. I'm also the caregiver for my business partner and wife. Barbara has Alzheimer's disease.

She can no longer communicate verbally or in writing, but she is in good physical health. I have had individual family coverage under Blue Cross/Blue Shield for many years. I pay $366 a month. I have looked into getting a policy that would cost less; however, I have always been told that any policy that I get would not cover my wife's Alzheimer's condition, or doctor, my wife, period.

While the initial diagnosis of Alzheimer's disease was somewhat costly, we have not incurred very much in medical expenses since then. The reason is simple: Alzheimer's disease does not require hospitalization. Medical costs, doctor's costs are low with Alzheimer's disease. The doctors can't do anything about it. Drug costs are low with Alzheimer's disease. They don't have any drugs for it. The medicines we use have been around for a long time. They are available generically—relatively inexpensive.

Even the most recent medicine that there's been a lot of to-do about, hopefully a breakthrough, being tested in 18 different places around the country, that medicine goes back prior to World War I. There are no new drugs.

Actually Alzheimer's disease has a very low claim ratio on your insurance. No expenses for the Alzheimer's disease are reimbursed expenses. The premiums are the same. However, there's the other side of the coin. It's not without expenses—with large expenses, ongoing expenses—year after year expenses. Depending on the family situation, there's day care; there's home care; nursing home care. Anywhere from $30 a day to $50/$60 a day and it goes on for years and years.

We have a group of men, one, his wife has been with Alzheimer's for 17 years. We have 3 that are over 12 years. The younger they are, the longer they live. The healthier they are, the longer they live. They tell me people don't die from Alzheimer's. You wouldn't have died if you didn't have it, but you don't die from Alzheimer's.

I'm fortunate in many ways because I'm self-employed. My hours are flexible. I can miss work; I don't get docked; I don't get canned; I can take my wife to work with me two or three mornings a week for 2 or 3 hours. It gives her a good change of pace. These are things I couldn't do if I worked for someone else. So the other families out there are in a lot more difficult position than I am.

I'm also fortunate that I'm in good health. As far as an Alzheimer's family is concerned, both my wife and I are quite young. Without maybe our youth, without maybe our good health, maybe I couldn't continue taking care of my wife at home. But in order to take care of her at home, we did have to change homes. A single family—or, a single story home, with bedrooms and bath all first floor—no stairs; actually, a wheelchair house. Changing homes is costly; the remodeling we had to do was costly. All of it attributed directly to the fact that we're trying to take care of Barbara in home.

As a facilitator for a men's group for the last 2½ years and as a member of the Governor's task force on Alzheimer's, I could tell you that many Alzheimer's disease patients end up in nursing homes prematurely. Why? Because they were unable to obtain or afford services necessary for continued care in the home. This is particularly true in the case of working spouses such as myself, working-age couples who are taking care of parents or a child and for elderly spouses who are in poor health and who are trying to take care of a spouse who is in worse condition than they are. It's a much happier situation for everyone involved when needed support services are available and affordable. Families and couples like Barbara and I would much rather be together regardless of the situation, regardless of the conditions.

I hope that your Commission will make recommendations that will result in improvements in long-term care, particularly home health care and other home services, and especially day care. Day care enables caregivers to continue working. It enables retired caregivers to get that respite, that chance to recharge their batteries and to go on and continue to take care of someone in the home.

I mentioned that I'm a small businessman. We do not provide health insurance to our employees. Prior to my wife's illness, we could not afford it. When we first got full-time employees, in the early 1980's in the Iowa economy, there was no way to afford it. It's more expensive now. I'm happy to say that all of our employees are covered by health insurance from other sources. I prefer that it be handled through our own company. A number of insurance companies have contacted us, offering plans for our employers—employees. When I say that the insurance must cover myself and my Alzheimer's wife, the conversation ends very abruptly. Any insurance that does not cover my wife is insurance I can't afford; insurance I don't want.

My own insurance premium has been creeping up lately. Creeping, hell. It went up 24 percent last year; it went up 94 percent the year before that. That's $4,400 a year. I pay for it all. My Government employer, my private employer, they don't help me, they don't pay any of it. And for $4,400 a year, what do I get? I get nothing reimbursed on my medical expenses. Things that would help me are not covered by private insurance, not covered by Medicare, if we had Medicare, not covered by the new catastrophic care, if we had that. Expenses we have are the day care expenses. That could amount to $7,000 to $8,000 a year at $30 a day. And that's a cheap service; that's well worth the money. I'm amazed that they are able to do it for $30 a day when you figure the almost close to one-on-one service that they would have with some of our day care here in Des Moines—fine services.

Home care, it can run $50, $75 a day. Nursing home—$50, $60 a day and more. It's $20,000, $25,000 a year. Those things are not reimbursed by any insurance yet. They are direct costs attributed to the disease. It's like a crap shoot. The dice comes up Alzheimer's, you lose. The dice comes up cancer, you win. Isn't that a lousy situation? [Applause.]

I'm going to depart from my sheet here for a couple of illustrations. In our men's group—we've got over 30 men in it. They range from—I'm the youngster, the only one trying to earn a living—on up to 92, a World War I veteran. By the way, out of 33 men, 17 are veterans. I don't know how this works the other way on the wives with husbands, but over half are veterans. We now have a veterans wing at—down at Knoxville—it's helpful for the veterans, not for their wives. Iowa takes good care of its veterans. It has a soldier home at Marshalltown. We used to call it the Old Soldier's Home. They have a very modern Alzheimer's wing. There, they can take care of wives as well as the veterans. It's very nice. As I say, Iowa does a good job with its veterans.

We have a gentleman close to 80, in poor health himself, taking care of his Alzheimer's wife. She was incontinent. He's got a kitchen timer; a 1-hour kitchen timer. He switches it over to 1 hour and sticks it in his pocket. When the bell rings, he takes his wife to the bathroom. Switch it back over to 1 hour, wait for the bell to ring again. Hour after hour; 24 hours a day. Not just daytime, 24 hours a day, 7 days a week, month after month after month. He finally got to the end of his string. He couldn't take it any longer. His wife went to a nursing facility; ended up on Medicaid. Later he said: "If I could have afforded, if I had had the money to have somebody come in 1 day a week so I could go to my neighbor's empty house and sleep, rest, recuperate, recover," he said, "I could have kept on, I could have hacked it for another year." That's about $1,300. For $1,300 he could have kept his wife at home for another year. Medicare was averaged out at more than $1,300 a month during that whole year.

What this does, it brings up the bottomline. Everything in our home, our business, our government, everything, we've got to get down to the bottomline. Well, there's two bottomlines in this. You've got this costly bottomline up here with Medicare. We've got a lower cost bottomline over here with home care. Things have to

be changed so that the system can chose the lower and the best and the least costly method of care for our people.

You've got to keep one thing in mind [applause] almost without exception, every Alzheimer's patient is going to end up in a nursing facility. Almost without exception, every Alzheimer's family is going to end up broke. The patient is going to be on Medicare. It doesn't matter if that's 2 or 3 months down the line, or 1 year or 2 years. Every day that that patient can spend at home with low-cost care is going to replace a day several months or years down the line when they are going to be in a home with expensive care. Somehow the system has got to be able to realize that the least expensive, the best, the home care, keep families together. [Applause.]

I'm not going to go into details on this, but we've got several documented cases where wives have had to divorce their husbands to get the care they needed. When you get to my age and older, or in 40, 50 years, marriage has had a test of time, you're still together—that's one hell of a thing to happen. It's devastating to the people. It doesn't happen very often, but it has happened; it's going to happen again, again, unless the system is changed. [Applause.]

I've given you an example of what home care can do. Here's another example. A few years ago when the day care first came to Des Moines, they had a lady—she had been taking care of her husband for quite a while. He was a shadow—pitty-patted right behind her, one-half step behind her all the time. The only time she ever had 15 minutes to herself would be if she could beat him to the bathroom and lock the door and then he was on the floor crying and pounding on the door, but she had a few minutes to herself.

Day care started here in Des Moines. She looked forward, she decided 1 day a week, looking forward to it. She had all plans for that day. She was going to get her hair fixed and all by somebody other than a neighbor. She was going to get some real clothes, the kind you can look in a mirror and you can smile instead of mail order. She took her husband to day care that first day; she went home; she cried for 2 hours, she slept for 6 hours; it was the most wonderful day she'd had in 2 years. She could afford that day care—$30 a day. She could afford it. She took care of her husband for another 10, 11 months at home. She could afford it. But what if she couldn't have afforded it. Her husband would have gone into a nursing facility, maybe not Medicare; probably on Medicare for 10 or 11 months.

So, again, for a lousy $1,300 a year, she stayed with her husband, he stayed with her, they stayed together and a lot of money was saved—a lot of money.

I thank you for this opportunity to share my experiences with you. Barb and I and families like ours around the country look forward to a more responsive long-term system that helps keep families together. [Applause.]

Chairman TAUKE. Thank you very much, Maury.

Maury, you indicated in your testimony that the insurance companies as soon as they heard the word Alzheimer's stopped the discussions. If the insurance companies aren't paying for care for Alzheimer's patients and if they don't have, as you indicated, much in the way of hospitalization care or care for—or costs for drugs be-

cause there really isn't anything, why is it that the insurance companies will not provide insurance? Does anybody tell you that?

Mr. HUNTER. Well, I think the actuaries haven't caught up with the times yet. I don't think they realize it.

Chairman TAUKE. The other thing that you mentioned was the problems that families face because they know that down the road they may face poverty as a result of all their money going into nursing home care eventually for those Alzheimer's patients. There is a lot of controversy, as you know, about catastrophic health insurance. One of the provisions in that bill, one of the provisions that I think is good, I suppose in part, because I helped put it there, was the provision relating to spousal impoverishment, saying that, you know, husbands, let's say, don't have to spend all their money before their wives qualify for Medicaid. That hasn't gone into effect yet, but are you familiar with that? Do you have any observations about those kinds of policies that we're attempting to put in place?

Mr. HUNTER. Yes, I'm somewhat familiar with it. I think there are some things that really are not clarified yet.

Chairman TAUKE. Yes, that's true. There are some State options and it hasn't—go ahead.

Mr. HUNTER. I think it goes a long way. I think especially some of these situations where there were divorces, I think it may help. For one thing, it raised the income limit to where a lady taking care of a husband, $70,000 a year out of her day care, didn't have enough left to live on and yet her income was too much to get nursing home care or what have you and, of course, there's no provision whatsoever for day care or home care, which is always a preference—to keep the family together.

Chairman TAUKE. I just want to commend you as I have several of the others who are here who are making this commitment for a family member, a spouse in your case. I think it really is a tremendous testimony of your commitment to your wife. Kathy——

Mr. HUNTER. It's not uncommon.

Chairman TAUKE. I know it isn't. Kathy, certainly, as we listen to your story, that commitment you're making to your mother, also was very striking.

I was reading an article not too long ago which said that women have crossed a major threshold. That up until about 1 year ago, a typical woman in our country spent more time caring for children than for parents. But about 1 year ago, the average woman in this country started spending a greater number of years of her life caring for her parents than for her children. And so, if that is indeed the case, then it would seem to me that there are many people who are going to be facing many of the challenges that you are now facing in your life.

I guess that struck me as somewhat surprising when I read it. I'm curious if you know of many people who are in the kind of situation that you are—attempting to care, almost on a full-time basis for parents or other family members?

Mrs. VERMEER. No, I really don't. I don't know of anyone who, who is presently doing this and I think that that's part of the problem when you talk to the people that don't understand the ramifications of it. Ideally, our situation looks like, oh, a doctor, a nurse,

this must be wonderful. I'm literally a hostage in my own home most of the time. I left my mother yesterday with my sister, whom I have tried to train in a few of the nursing skills because there was no one else. My husband was coming home at 7:30 p.m., from the hospital to start his shift with her and as I left, I had a very nervous looking sister walking upstairs and checking things with me and saying: "How do I do this?" I am at an advantage because I have this training.

And there are so many people out there that want to do the same thing if they could get a little help from the government. I don't even want—I don't want someone to replace me totally. But I need a day off, you know.

Congress adjourns, there's no adjournment in our house; 365 days a year. A simple reciprocation. [Applause.]

My mother's care is the first thing that's checked in the morning and the last thing that's checked at night and it's just ongoing. I mean, I suppose you could relate it to a dairy milk farmer who knows that those cows have to be milked twice a day. It's something that you just can't handle——

Chairman TAUKE. Is it more of a mental burden, let's say, if that's the right way to put it? Or more of a burden, let's say, than caring for an infant? Is it comparable?

Mrs. VERMEER. I'd say, with an infant, you know that the infant is going to progress and start gaining independence. With someone such as my mother, you're watching this work backward and you know that it is going to be a deteriorating type of situation. I know, in my mother's case, we kind of foresaw this and—like many people in her age group want to maintain their independence and it's very difficult that—I think a lot of people who talk to the elderly have got to listen to what they want. They have to have a choice in this and they have to feel like they're making this choice right along with you. The people in hospitals are saying, well, then, Joe Smith will just have to go to the nursing home. They're not Joe Smith; they don't know what Joe Smith wants. And they have to look at other alternatives and they have to bring Joe Smith who's living that life, or is going to be living that life into the situation. I think that's extremely important.

And people like myself, we are not—it's so unusual, I suppose, in some ways, that the health insurance system doesn't know how to deal with it. They only want to pay nursing agencies.

I was trying to investigate a $10 a month rider for my mother's current policy which would pay for $30 a day for 40 days annually. I could use it all up at once, or I could spread them out, that would pay toward a nurse or a home health aid, which would at least take some of the financial burden away. In essence, I would be paying $120 a year for $1,200 worth of services. And I said, oh, that's good. I know another nurse that might be willing to do this. And they said, oh, I'm sorry, this nurse has to come from an agency. The agency nurse is $22 to $28 an hour and the nurse I could get was $12 an hour. So, it's against you. They will not let you do this——

Chairman TAUKE. So, even though it's in the best interest of the insurance company, or in other cases, in the best interest of the

Federal taxpayer, the policies continually work toward the higher cost—in favor of the higher cost system of delivering services?

Mrs. VERMEER. Absolutely. And they are all skilled care. I've called Medicare three times and I've looked at the little booklet on the catastrophic bill that's coming up. Medicare of Iowa does not have the answers for me and they said they won't have the answers until December 1989. I have said: "What nurse are you sending in to replace me? Is this true?" And they're baffled. They said: "Well, I'm not sure that's true."

I've tried to investigate those clauses concerning the respite of skilled nursing care which is different than home health care and no one has the answer and these are supposed to be people in charge.

And I said: "Am I not understanding this?" I have this little catalog underlined and I've called and talked to different people. They're saying, no, I don't believe you'll be getting a nurse. Well, I need a nurse. I need someone like me. What are they going to give me? As I mentioned before, you don't ask a stewardess to pilot your plane. I want, I want [applause]——

So, we're not asking the Government—we're not saying to just take care of us. We're just—we're asking for, as you said, a little refueling, and the time to, to live our life a little bit and get it together. We want some of those things that are only offered to patients in nursing homes. And the nursing homes, I think—that's another problem, I think, is nursing home care—that the Government pays a lot of money on poor care and if they would re—if they would reevaluate the money they are going to give out, they would give it to some of these other families. It's working backward. It doesn't make sense.

Chairman TAUKE. Betty, you gave an interesting analysis of what is being done by area agencies on aging for case management. Do all the area agencies on aging provide case management services now across the State?

Ms. GRANDQUIST. No. We only have six projects. And we're evaluating those very carefully, looking at the costs and seeing what they really accomplish before we spread statewide. But we're hoping in this coming session, to put it statewide. They try to do the things you're talking about bringing in the persons themselves and/or their families and while they talk about what services do you need to stay at home? They do find that sometimes that the person involved, says, I don't want that.

Chairman TAUKE. But, in other words, the reason I went this direction with the questions is, the problems that they have are the kinds of problems this case management service ought to be able to address if we can move in that direction?

Ms. GRANDQUIST. Yes. And to put a package together so they can stay in the home. That would mean calling on volunteers maybe to go into respite, but in your case, you need someone other than a volunteer probably. But whatever is needed, at whatever level, to help that person stay at home. And we do find out that many times, they don't qualify for title 19 so, well, in fact, 80 percent of the cases that—with multiple problems so far are people who would not qualify for title 19. So they kind of help with the financial package where you can get help if there is any available.

Another interesting thing we found out is that's it's over half—I think it's 56 percent qualify to go into a nursing home. They are called and that would be fine.

Mr. HOWARD. If I could just follow up, Ms. Grandquist, of that 80 percent, what you can really do for them is put them in touch and coordinate what's already out there. You don't have any independent funding that's available?

Ms. GRANDQUIST. Oh, no, no. No, we bring the services that they need, those agencies come together and sit down and say, that their first contact was the homemaker/home health person. That person will stay the case manager. But these other agencies will go over all the services with them and what we've found many times is that mental health services may be overlooked. Depression, of course, is very, very common with older people. Not just that they have lots of things to be depressed about, but sometimes there are actually chemical changes that bring the depression about. Some of the other human service agencies are really a little slower picking up on that and the mental health person will say, oh, look, we can have our mental health outreach person go talk to you if you like about some things available. And we're finding great success with that portion of the case management.

Chairman TAUKE. Thank you very much. We appreciate your testimony this morning.

Our last panel, if those individuals would come forward. This has been a very good audience. Even though we've been sitting here for about 3 hours, I suggest we all stand up for about 1 minute. But because we are late on the schedule, we will move right along.

[A 1-minute intermission was taken.]

Chairman TAUKE. If we could come back to order.

We have a lot of information to pack into our last 45 minutes to 1 hour here, so let's move right along if we can.

Our first witness in this panel is Beth Fuchs who's a specialist in social legislation with the education and welfare division of the Congressional Research Service [CRS]. I think this is Beth's first time to Des Moines, right?

Ms. FUCHS. True.

Chairman TAUKE. So, welcome to Des Moines, Beth. It's good to have you here.

STATEMENT OF BETH FUCHS, SPECIALIST, SOCIAL LEGISLATION, EDUCATION AND PUBLIC WELFARE DIVISION, CONGRESSIONAL RESEARCH SERVICE

Ms. FUCHS. Thank you Congressman Tauke. I'm pleased to be here today to share with the Commission some of the findings of a recent Congressional Research Service study entitled Insuring the Uninsured: Options and Analysis, which I coauthored with Mark Merlis. For the benefit of the audience, the Congressional Research Service is a nonpartisan support agency of the U.S. Congress.

Our report covered a wide range of insurance issues. However, at your request I am going to focus on the question of availability of home coverage for individuals and for small employers. I will explain some barriers that individuals and small employers face in purchasing health benefits and highlight some of the changing fea-

tures of the insurance market that appear to have increased these barriers over time. In my written testimony, I also suggest issues that arise in conjunction with options that seek to increase the coverage through the private insurance market, such as voluntary pooling mechanisms.

Let me start, however, with two qualifications. The first is there because of the dynamic and complex nature of the health insurance market. It is very difficult for me to make generalizations about how the health insurance industry operates. Some of the practices I'll be describing may be more prevalent in some regions of the country, or in some sectors of the industry than in others.

Second, health insurance is costly largely because health care is so costly. I will discuss some of the factors that make insurance more expensive for individuals and small groups than for larger ones, but even if small employers could buy insurance at the same rates as larger employers, the costs might still be prohibitive. After all, as you've heard, if a firm has little or no profit, any cost of health insurance may simply be too high. Indeed, the cost barrier may grow if health insurance premiums continue to climb faster than either prices in general, or prices for medical care, a phenomenon that we have witnessed over the last decade at least.

Having noted these qualifications, I'd like to begin by tracing some of the developments in the insurance market that have led to the prevalence of grading and underwriting practices that make it so difficult for some individuals and small employers to purchase health coverage that is affordable.

The private health insurance system has evolved over the course of this century largely in response to the operation of a free market. Gradually there's been a move away from cross-subsidization of the costs of health care coverage to a market that is greatly fragmented.

In the thirties, the original Blue Cross plan and other such plans offered insurance at fixed rates to all purchasers. Under this "community rating system," low-risk individuals and groups subsidized the costs for higher risk segments of the insured population. But this soon began to change. The rise of competition from commercial insurance companies in the 1940's led to a crucial innovation, that of "experience rating" for large groups. Low-cost large groups demanded, naturally, that the rates they paid for coverage be related to the costs that they incurred for their group alone. The commercial insurers met this demand. But to compete for this business, the Blue Cross and Blue Shield plans also had to begin to do some form of experience rating. At the same time, some large groups found that they had sufficient resources to drop on the insurance market altogether and to essentially, self-insure. This further reduced the pool of firms seeking coverage in the community-rated market. And today, nearly 60 percent of the Nation's employees with conventional coverage are enrolled in a plan with some aspect of self-insurance.

The result is that the original community of insured people have been fragmented into discrete populations. Some employers can buy coverage readily at standard rates, or it can provide their own coverage. Other employers and individuals without access to the

group market must pay higher rates or cannot find coverage at all because of the insurance industry's underwriting practices.

I'm not saying that insurers or large purchasers of insurance intentionally set out to create the problems for the high risk end of the market. It is simply that classification of risk is a fundamental concept of all types of insurance. As insurance competes for the business of the groups presenting the most favorable or predictable risks, the competitive insurance market has worked to reduce the degree of cost subsidy and the cost of health insurance.

Without such subsidies, high risk groups and individuals are going to face a much more expensive market and a more difficult market to penetrate.

I was asked to discuss the basic underwriting practices used by insurers in deciding on coverage for individuals and small groups. First, let me turn to employers and then I've been asked to give short shift to individuals in the interest of time.

In deciding what employer groups to accept and what premium rates to offer them, insurers considered characteristics of the entire group, such as the type of business in which it is engaged as well as characteristics of individual members of that group that may predict their figure need for health care services.

Several characteristics of firms may lead some insurers to either deny that coverage or to offer coverage only with very special restrictions or very high rates. For example, some industry groups such as restaurants, hotels, contractors, and vacation resorts experience seasonal employment. Insurers know that typically medical care utilization of seasonal employees will peak just before layoff or dependents will seek medical care just after the employee goes back to work. So insurance may deny coverage to such an industry or offer it coverage only at high rates.

Other small employers may be denied coverage because they are in industries that present a high risk of occupational illness or accident. Typically you'll hear mining, logging, commercial fishing, and oil exploration as examples, but there are many others. Finally, some companies may pose credit risks because they are in a line of business with a high failure rate, such as small restaurants, or simply because they themselves have a poor credit history. Since different insurers use different criteria the company excluded by one insurer may eventually be able to find coverage from another source, but that depends on a whole lot of effort to go out and find that source.

However, regardless of the nature of their business, small groups may face an additional barrier to coverage, that of underwriting—medical underwriting. For groups of fewer than 10 to 15 workers, an insurer may require medical information about each employee. If some members of the group are determined to present high risk, the insurer may follow any of a number of courses, and of course, I'll add as an aside, we've seen illustrations of this all through the testimony this morning.

The whole group may be denied coverage completely. The insurer may offer coverage to the group only if the high risk employees are excluded and the insurer may permit the inclusion of these employees but increase their rates to the entire group.

Even if the group is not determined to especially high risk, other limitations might apply. The policy may exclude coverage for pre-existing health care conditions, or impose a waiting period for that coverage to begin. Finally, insurers may be concerned that within the approved group, only employees who foresee a need for health care will actually participate in the plan. If this occurs, of course, the higher cost enrollees will not be balanced by those lower cost, healthier ones. For this reason many small group policies require minimum participation levels. In the very smallest groups the policy may require that all eligible workers enroll in the health plan. And to achieve this very small portion will be told that they'll have to pay 100 percent of the premiums for their employees.

The process for underwriting an individual is similar. Assuming an individual can find a company that sells individual subscriber policies, the insurance company will require of that individual applicant either a health care statement or much less frequently a medical exam. Other criteria are also used, such as the health habits of the individual, the age, the occupation, and even sexual preference. On the basis of this evaluation the insurer will classify the individual as a standard risk and give him the coverage, or substandard risk and perhaps rated very high or deny them coverage completely. These, then, are just the basics of medical underwriting, and of course, as I mentioned these have to be generalizations.

Let me now just turn for a moment to the cost factors that go into pricing insurance policies with the small group market. I would like to forego talking about individuals at this time, but as mentioned earlier, individual subscriber policies are generally going to be much more costly. The first basic generalization is that small employers who clear those underwriting hurdles and obtain health care coverage, will generally pay more than larger groups for an equivalent health care plan. While estimates vary, premiums for the smallest group average 10 to 15 percent higher than premiums charged to larger businesses. This cost difference is generally not due to differences in the cost for providing the covered benefits. Underwriting has already screened out the bad risk or factored their existence into the rate. Instead the difference is due to the higher cost of administering the group plan, insurer's cannot, for example, take advantage of economies of scale and processing claims. Commission costs in what we call risk and profit charges are also going to be higher for the small groups. Also small employers may pay more because of external factors such as State-mandated benefits laws, and also the differences in the treatment of self-employed businesses. These are a little bit more controversial, and you can probably make arguments on either side for those particular factors.

While these factors account for higher initial cost for coverage, small employers often tend to find that their premiums will increase rapidly after the first year of coverage. This is because of the dynamics of the smaller group market in which there is a whole lot churning, that is companies charging insurers—companies changing insurers or leaving the market entirely. Let me spend a moment on this churning phenomena. If the small group is medically underwritten, it may start out with a healthy pool since

the group members with a known immediate need for health have already been excluded. Over time, however, those left in the pool will gradually use medical care at greater rates. The cost of claims paid under the policy rises, many insurers will then raise the rates after the first year of the policy. As an alternative some may offer to reunderwrite the group, again separating the currently sick and the currently healthy. There may also be cases in which insurers will quote artificially low rates for the first year in order to gain new business. Employers who present the best risk, then, may respond to annual rate increases by seeking a new insurer who will offer them more affordable first-year rates as a result.

While insurers are competing more vigorously to the groups that present more favorable risks, their renewal business may increasingly consist of higher risk groups unable to find a lower price. If this spiral continues indefinitely the effects of further fragmentation of the market, this then is how churning leads to more difficulties to the high risk smaller groups. It sort of creates the never-ending spiral of problems. I have provided just a very brief explanation of why the purchase of health insurance for individuals and employees and the salaries of smaller employers can be problematic. The situation can be summed up as follows, and certainly has been summed up today; coverage is sometimes unavailable entirely and for many more it's simply just not affordable. We don't know whether these variances in coverage are likely to increase, but most indications from the industry suggests that they will.

Thank you again for the opportunity of appearing before the Commission.

Chairman TAUKE. Thank you, Beth. I want to commend you for the tremendous additional written testimony you've given us, which is enormously helpful to us. Second, our second witness is Earl Pomeroy, who is vice president of the National Association of Insurance Commissioners [NAIC] coming to us from Bismark, ND, and he is accompanied by Trevor Smith, the insurance commissioner of Florida, who is chair, as I understand it of the NAIC Committee looking at the small group market. Earl, please.

STATEMENT OF EARL R. POMEROY, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. POMEROY. Thank you, Congressman Tauke, and as the commissioner of insurance from a midwestern State, I commend you for bringing this hearing out to the heartland and commend your staff and succeeding witnesses for the truly compelling testimony that has been evidence in each of the preceding panels. I'm testifying this morning as vice president of the National Association of Insurance Commissioners, insurance being primarily regulated by the States our activities are closely coordinated through the NAIC and the association of each of the insurance commissioners of the 50 States and 4 Territories. Trevor Smith is the assistant insurance commissioner for the State of Florida. The State of Florida does, as you mentioned, chair the pertinent committee studying the problems in the small insurance group marketplace.

The broad jurisdiction of the Pepper Commission involves a number of areas, presently subject to NAIC action particularly including long-term care insurance minimum standards. Our testimony this morning will be focused on the small group marketplace and we would be happy at any point in the future to discuss our activities in other relevant areas to the Commission and with your staff in the future.

Chairman TAUKE. Thank you.

Mr. POMEROY. At the outset I want to emphasize that we have found a tremendous complexity involved in developing an appropriate regulatory response to the small group health insurance area. Substantial losses have been realized in the health insurance market, in general the small group market in particular over the last few years. A number of companies formerly vying for this market have left dramatically reducing the number of options available for a small business. An inappropriate regulatory response may further diminish the number of companies willing to write this business and discourage other companies from entering the market making the present availability problems even worse. In addition, unrelenting medical inflation which has consistently run well ahead of the general inflation rate has driven charges for both hospital and physician services to their highest levels ever. Accordingly, the costs of the health insurance premiums are also at historic highs and projected to rise at double-digit rates into the future. In this setting many small employers can no longer afford to continue to provide health insurance benefits. Many others who are presently struggling in their efforts to continue health insurance coverage for their employees would be adversely impacted arguably to the level of being unable to continue this coverage in the event a regulatory response would dramatically impact premium pricing considerations driving up the costs yet further.

I want to emphasize that health insurance costs are primarily a reflection of the actual costs of health care. No Government response can stabilize the rising cost of health insurance without addressing the underlying issues behind the soaring costs of health care services. In the balance of my remarks this morning I will outline briefly the status of our review of premium rating in medical underwriting activities occurring in the small group market and indicate areas likely to be addressed at the annual meeting of the NAIC in December in regulating these problems.

Central to our discussions to date involve a focus of fairness and equity of insurance company rating practices. At this point the committee has not made any formal recommendations to the NAIC members on the rating issue, however we are closely monitoring the developments in some States that have already addressed the question. For example, some States have implemented limits on the practice of tiered rating. Tiered rating is a practice which divides the pooled groups into small groups of tiers based upon experience levels in order to minimize cross subsidization of the most expensive group. A group's prior claim experience is used to select a level of renewal rates. The practice of using experience for renewal rating is largely accepted—for large groups, it is not as actuarially appropriate for small groups. Nevada and Maine have limited the amount that tiered rating based on experience impact can have at

the time of premium renewal. The highest tier, for example, in the State of Maine may be no more than 20 percent above the average, which is weighted average based on the amount of business in each tier.

Both Maine and Missouri require complete disclosure of tier rating practices in company's solicitation or sales materials. I believe that a NAIC response will do more to require disclosure of actual rating practices at the time of sale of a policy to a small business than has been required previously. Durational rating is a practice somewhat similar to tiered rating in which rate increases are periodically implied to each group within the pool depending on the age of the policy that has been in place. The rates on small groups move higher at each renewal to mitigate the impact of the aging curve. Restrictions on durational rating have been proposed in Wyoming and Texas, and these proposals are being carefully studied by the committee.

In the underwriting area, the effect of underwriting on the availability of coverage is being explored. Group business is commonly underwritten in the small group market. The States of Massachusetts, Ohio, and Florida have explored restrictions or prohibitions on underwriting in the health insurance area. The impact and rationale behind those proposals are also a subject of committee review at this time.

Other marketing practices which have drawn concern involve discontinuance and replacement, churning as was mentioned by Beth, extension of benefits, coordination of benefits, cancellations, and postclaims underwriting. Other related issues such as the effect of mandated benefits on the availability of coverage and the effective increasing medical costs on the affordability of coverage arise and will continue to arise during the course of our committee's discussions. Although resolution of these issues are not the focus of this committee's deliberation they deserve our careful attention and the careful attention of the Commission as well.

The committee has developed preliminary regulatory strategy, a form of which I believe will be adopted as the proposed NAIC model at the December meeting. I believe that we will go along these lines. We will require greater disclosure of rating strategies as I mentioned earlier. We will require actuarial certification of the rating strategies used by insurance companies to be filed with the insurance department for their review and approval. We will identify and prohibit abusive marketing practices. Some of the prohibited practices being explored include placing a limit on the range between an insurer's new rates and its highest durational or tier rating increase in order to mitigate the churning problem, limiting the frequency of movement among rating categories, and limiting tier and other durational methods. More developments on these issues will occur as early as the September NAIC meeting in Wilmington, DE, as the work of this committee progresses. We will be happy to share our findings. We look forward to the continued dialog with the Commission and thank you for the opportunity to appear this morning.

Chairman TAUKE. Thank you very much for your testimony and we look forward to getting a report from your commission when that report is completed. Our next witness is Ray Crabtree, who is

the senior vice president of the Principal Financial Group here in Des Moines. Ray, thank you for being here this morning.

STATEMENT OF RAY S. CRABTREE, SENIOR VICE PRESIDENT, PRINCIPAL FINANCIAL GROUP

Mr. CRABTREE. Thank you, Congressman, I appreciate the opportunity to appear before your Commission and provide input. I have submitted some materials in writing, what I would like to do is highlight three points out of that material for you, two of them talking about the small employer health insurance situation and one regarding long-term care insurance.

First, if we're going to talk about the health insurance problem and the uninsureds, we must talk first about health care costs. Insurance costs where employee benefit plan costs of self-insured are very simply, you would want to analyze the cost, they are the total of the claims paid plus the cost of administering those benefits. Claims are very clearly the largest piece of that program, and this formula that cost equals claims plus expenses, is true no matter whether it's the Federal Government that's the buyer, the insurance company, or a private employer.

Since claims are the largest piece of that formula, if the claims cost is uncontrolled then the insurance premium and the total cost of the plan will also be uncontrolled. This is the most important factor that we need to focus on as far as trying to expand the number of people covered for health insurance in the United States is the cost of health care. The health insurance industry is very strongly attempting to control those costs, but it's also very clear that we cannot do it alone. Health insurance costs are a very complex subject, they are addressed by many different factors in the Nation. Provider industry is very much still a cottage industry in the United States. Health care is a regional local cost item. It is not one monolithic unit in the United States.

So while the health insurance industry can aggressively speak to this issue, and are speaking to this issue quite aggressively, since we are not the only buyer, since we are not the only factor, it's impossible for us to alone control that terrible cost in what we're really talking about is the rate of increase in that cost. Now, the Federal Government is very obviously a major factor in the cost of—or in the purchase of health care in the United States. They are both a positive and a negative factor. Some of the things that the Federal Government has done have very clearly had the wrong impact. Let me talk about the things they can do in a positive vein. It was referred to earlier today that there is activity going on at Health Care Financing Administration, HCFA, to help develop standardized treatment patterns. That activity should be aggressively pursued. We need this sort of help into the system so that we increase the amount of attention brought to the practice of medicine so that these standardized treatment patterns help us eliminate the unnecessary care that was also referred to today.

Another activity that is being pursued at HCFA is source base relative value scales. That activity shows great promise to help us better analyze the appropriateness of cost, the source of those costs and then pay appropriately. The reason I emphasize these two ac-

tivities is that artificial lids on the costs will not work. It doesn't matter if we're talking about artificial lids imposed on Medicare and Medicaid or if we are talking about the control artificially of insurance premiums. Artificial lids won't work because they are not addressing the cost of care. Instead they are addressing the price of a passthrough carrier rather than the cost of its source.

Ultimately, long term, if we are going to control the cost of health care in the United States, we must pay attention to the cost source which comes from the providers of health care. So more attention on these two particular items would hold great promise, that's the treatment patterns and the resource base of relative values here.

Let me change and talk about the selection of risks. Insurance plans do one thing, they really share risk amongst a large group of people, they do not create money. What they do is take a given source, a given amount of money from a large number of people, put it together in a pool and allocate it back out. There is not an unlimited source of money for an insurance program. So if you're going to share with your fellow members of this resource pool, whichever insurance program, whichever it is, it has to be done fairly. And similarly to choose within the insurance industries you cannot insure burning buildings. Well, if we're going to be fair to the insureds in a program we have to make sure that the people that are allowed into the program with their limited amount of dollars are not people who will immediately use the program, that they didn't buy the insurance because they immediately needed it. Insurance is not for predictable events, it's for unpredictable events. Risk selection is a very financial key to the survival of a private program. Government uses it too. You find significance risk selection techniques in the Medicare Program, but I will admit that the process can certainly be abused.

Very briefly they include some possibilities that are already in place in some places in the Nation where we can expand that we can probably improve further on the system of private care that's being provided, and I might also add that some of this is the same things that are being considered by the NAIC committee that Commissioner Pomeroy referred to. We would suggest that there should be a limitation on, or a requirement that a transfer from one carrier to another not allow anyone to lose coverage or being covered. That is required in some States, it's a very positive way of controlling an employer abusing other insured individuals. A limit on preexisting conditions is not unusual, but it should be accompanied with a full coverage provision at some point in time. A collective underwriting technique is used in many States whereby the insurer or the provider of services to that program must agree in advance to take all of the people or none, that does work again to protect the interest of the insured people who are at risk.

It would not be unreasonable to consider the elimination of riders which eliminate coverage for specific health provisions. It would also be possible and very reasonable to require all employee benefit plans to make available the privilege to convert to an individual policy upon termination of employment and is not currently surprisingly a national requirement. The Federal preemption of State-mandated benefit laws would certainly help the cost to small

businesses and should be considered by the Federal Government and then definitely small self-employed businesses clearly deserve a 100-percent tax break for the premiums they pay just the same as large corporations do.

Now to go along with that sort of thing, it is also possible that it may be necessary at this time that all employers either be required to cover all of their employees for an employment benefit plan or an alternative approach as was mentioned here earlier not unlike the Enthoven plan of your earlier proposals, where all people in the United States be required to carry insurance is the vehicle to do that. It may well be that this is the time that we should do something like that. But, please, in light of everything else said here today, recognize that the Federal Government must expand Medicaid, that is clearly the only source for the low-income people in our Nation and a Medicaid buy in for what we've been referring to as the near-poor is also a very reasonable answer for many of the things we heard about today.

An expansion to the entire Nation of high risk pools for uninsurable is also a very reasonable step that should be strongly encouraged. Let me say just a few things about long-term care. Very clearly this subject needs very great financial emphasis at the present time. There are roles that are very appropriate for both the public and the private sector. Government must care for the low-income individual, no question about that. But there is a significant cost burden that the private sector can remove from Government if the private long-term care coverage plans are encouraged. There is developing currently an employer-sponsored plan marketplace. If the Government was to grant those benefits, those premiums and those benefits, the tax-favored status, the same that is true today for pension plans and health insurance plans, this would encourage the development of that marketplace. More employers would provide programs, more employees would participate. Clearly the more employees that participate in those programs, the more individuals that can meet their own needs, the better off the Nation will be, the lower the burden long term on the Government. So a tax-favored treatment today in exchange for somebody meeting their own burden down the road is very reasonable.

Private plans both in long-term care and in health can work for the Nation's good. They provide a flexibility that is very desirable. We strongly encourage the preservation of that system. I'll be very happy to answer questions at the end. Thank you very much.

Chairman TAUKE. Thank you. You packed a lot into a short period of time.

Our final witness this morning, batting clean up, is Janet Griffin, who is associate counsel of Blue Cross and Blue Shield of Iowa. Janet, we thank you for not only your testimony, but also your willingness to wait such a long time to present it. Thank you for joining us this morning.

STATEMENT OF JANET GRIFFIN, ASSOCIATE COUNSEL, BLUE CROSS AND BLUE SHIELD

Ms. GRIFFIN. We certainly appreciate the opportunity to present information to you this morning. We are particularly concerned about the problems of the uninsured population and particular needs for families and individuals that have special needs for long-term care. The testimony that we've heard this morning is compact, and any of us that have been sitting here hearing it cannot help but be moved. The impact on the individual families involved, their personal situations, it's clearly a devastating situation with people involved in those particular situations.

The Iowa-based Blue Cross/Blue Shield organization are among 75 nonprofit organizations around the country. They vary considerably in terms of their size, their business practices, and as a result it's difficult for us to make broad generalizations about the practices used by the individual clients. My comments today are focused on those business practices that we are most familiar with, and that is those of Blue Cross and Blue Shield of Iowa. To the extent that we are knowledgeable about some other Blue Cross practices, we will be happy to share that information with you and try to provide some information.

The Iowa-based Blue Cross plans provide a broad array of products that are available for the small group and individual market and we cover benefits that are available for Iowans throughout their lifetime, from prenatal care and well-baby care to long-term care, including adult day care and nursing home provisions. We also recently have introduced a new product that's specifically designed for low-income Iowans who do not have coverage through their employer or are not able to purchase the coverage that is out there available, that has more generous benefits. These are just a few of the ways that we try to live up to our determination to provide coverage for those segments in the population that perhaps have not been covered by some of the traditional carriers. We have identified the uninsured population as a key concern of ours, and I believe there is a role for the private insurer carrier, private insurance carrier such as ourself to meet those needs.

In 1988 we conducted a survey of the uninsured population in Iowa. This was the first survey which focused on Iowa's specific data as opposed to an extrapolation of some national data from the census bureau. And earlier this year, in 1989, we worked in conjunction with other representatives of the insurance industry and the State government officials to take that data and further refine it. What that data disclosed, Paul Pietzsch referenced some of that information generally this morning. What we find is that in Iowa's almost 3 million population, 14½ percent of folks under age 65 are not covered by public or private health insurance coverage. And as you heard this morning approximately one-third of those folks are children under the age of 18. The remaining two-thirds involve adults, and what we find on our study is that about 40 percent of those adults are not insured but they are working in seasonal or part-time jobs, and also note 30 percent of those are self-employed or work full time.

So what we're seeing is that almost two-thirds of those folks do have an employment relationship of some type or another. We also find that 64 percent of the working uninsured are employed by companies of 25 or fewer. What this survey demonstrates is the uninsured population in Iowa, is very similar to the national statistics. What might be a little bit different is that small businesses which traditionally do not provide coverage to their workers have been the backbone of the Iowa economy, and while from the State's standpoint for economic purposes we've encouraged the growth of small businesses. It's pretty clear that changes need to occur in the availability of coverage to small employers or the economic growth that we see in Iowa will only mean that we have a higher number of uninsureds in our State.

The research that we conducted included surveys of the uninsured and small groups to determine how much individuals were willing to spend for their health care coverage. What services they want covered and which services they might be willing to give up in exchange for lower, a lower cost product. We also looked at what small employers might be willing to do in terms of administrative responsibilities as a way of keeping their costs down or in lieu of contributing part of their payroll toward that. The results of this survey have convinced us that there is a marketplace in Iowa for streamline low-cost benefit product that can meet the needs of the uninsured without sacrificing access to good quality care.

We also believe that the workplace, the small employer can be an effective way to get that product to the individuals to distribute it, and in response we have developed a basic benefit program which is available to individuals through direct payment or can be provided through a small employer. The product is a medically underwritten age-rated, preferred-provider product, and it features the managed care provisions as a way to hold down costs as well. These include second opinion, mandatory outpatient procedures, precertification, and so forth. For about $50 a month at age 45 individuals would have access to services with inpatient hospitalization, outpatient surgery, and emergency and accident care. In exchange for this low cost, however, the benefits are limited and they do not cover certain major medical provisions such as the drugs or durable medical equipment. They do not cover mental health and substance abuse benefits, maternity benefits, or most transplant coverages as well.

In conducting this research what we found out was that consumers were willing to trade off these excluded coverages if they could get those basic services at a reasonable cost. In addition, what the survey told us is that in many cases a catastrophic program has a high front-end deductible, is not a product that is suitable at all for this particular market. So we designed our product to have copayments instead. For example, there is a $10 per service charge for physician services, $50 for outpatient services, or $200 for inpatient services. We think coverages such as this might address the needs for certain key segments of the uninsured population, and in introducing this product we join many other Blue Cross plans around the country that have developed similar type products for the uninsured population in their own States.

In addition to our product development activities, we've also supported State legislative studies of the government options that might exist in this area. In support of increased marketplace activity by other insurers we have proposed certain task programs that might encourage the development of these products. First, we've proposed that the premiums generated on this type of basic product be exempt from State premium tax for a certain period of time. This will allow a product to be offered at 2 percent below the cost that would otherwise be charged. It also is a program similar to what was done as a public policy stand to encourage the development of health maintenance organizations in the last decade. We also suggest that insurers that offer this kind of product be entitled to take as a tax credit against their premium tax liability any loses they incur in excess of 100 percent for these particular basic benefits, products.

We also had planned that these particular tax incentives are budget neutral in the sense that they are pegged to products that are not currently out there, these premiums that are not currently being collected and therefore they're not included in the current revenue projections for the State government. In addition to the basic benefit program which can target the working poor, the working uninsured, was also focused on another key segment of the uninsured population in our State, and that is children. We and 15 other Blue Cross and Blue Shield plans around the country have developed the Caring Program for children. A Caring Foundation has been set up as a charitable foundation that provides the money for eligible children to receive primary and preventive health care services. In this way individuals and corporations and civic organizations can make tax free contributions to the program. The emphasis in the program is on early preventative care and it provides coverage for benefits that are not typically covered under a traditional product, either immunizations, yearly physicals, well-baby care.

We think that programs, such as this, meets the very real needs that exist out there right now, and it can serve as a transition until a more comprehensive and broad-based approach can be developed perhaps at the Federal level. The value of a program such as this has been recognized by the State of Iowa. This year the Iowa Legislature appropriated $1.2 million to the Caring Program over the next 3 years, and the private contributions that can be made to this Caring Foundation also provide an opportunity for the public and private sectors to work collaboratively in addressing the particular needs of this uninsured population.

In closing I would just like to note that my overview has touched on the major initiatives; some of the activities that Blue Cross and Blue Shield in Iowa is undertaking. And we hope that you will find it useful when you look at developing a blueprint for dealing with the problems of the uninsureds both within Iowa and the Nation as a whole. Thank you.

Chairman TAUKE. Thank you very much. Thanks to all the witnesses on this panel.

Janet, starting with you. In this basic benefit package which you described, which is interesting, what kind of public response have you had? Well, maybe I should first ask are you marketing it yet?

Ms. GRIFFIN. We have just started our marketing campaign. We don't have any enrollment statistics yet. It's literally just off the drawing board and we're just out there in the marketplace.

Chairman TAUKE. Would it be fair to say that in essence this is something that many, probably low middle-income individuals would be—you would be targeting lower and middle-income individuals with this kind of plan?

Ms. GRIFFIN. We hope to focus specifically on those perhaps small groups of individuals who do not have coverage for whatever reason through their workplace. As I said, it's an age-rated product and clearly with the basic limited benefits it is designed to be attractive and available for folks on a limited income.

Chairman TAUKE. Generally the theory of insurance is that it will take care of the biggest problem that you might face down the road and then the smaller problems you can take care of yourself. This insurance package, though, is designed, as I understand it, not to deal with the biggest problem. Are you relying on essentially the Medicaid Program to take care of this kind of problem for an individual who would buy this type of insurance?

Ms. GRIFFIN. I think you're right in viewing this as sort of a basic, limited program. What some of us think is this is more like a Blue Cross/Blue Shield product looked 50 years ago, which is a case for some basic benefits. It doesn't pay for the preventative care. It clearly leaves a need for the Government to step in at some point in time, you're right.

Chairman TAUKE. Take care of the catastrophic?

Ms. GRIFFIN. Yes, it is not the answer for everybody, it is not the answer for all problems. It may serve a useful role as a transition product until we can deal with some of these problems.

Chairman TAUKE. For people who have no coverage now it certainly provides a much better situation than they face otherwise. It will be interesting to see what happens in the marketing.

We have heard quite a bit today in our discussion about underwriting practices which affect small group coverage. At least as I understand it Blue Cross and Blue Shield did not follow some of the practices that have been described here today, but has begun to do so in recent years. Can you tell us why the Blue Cross/Blue Shield has begun to follow some of those practices? And how has this affected coverage for smaller groups?

Ms. GRIFFIN. You're quite right, and many people have commented on the fact that the Blues suddenly no longer look like any special organization, they look like any other part of the insurance industry. I think part of it is an historical reason, and that is when Blue Cross organization first started 46 years ago, there were no other players in the market, and it was an acceptable way to pool all those risks, there were no other parties out there trying to siphon off the best risks and community rating certainly was common.

Our plans do engage in community-rating practices, particular in the individual market and the small group, more so perhaps than some other organization. Why have we gotten away from it in perhaps other market segments? Part of it is that there are more players in the market to the extent that they can pull off the better risk groups and by thorough experience rating provide a

more attractive rate to a particular individual employer. It is to the employer's financial interest to pursue that other coverage, and what that means is that the pool of individuals covered by Blue Cross is left with a shrinking pool who are there because perhaps they are not a good risk and are not pulled off by other carriers.

That's probably a long-winded answer, but I guess the short answer is that as we've had more competition we've had to respond to that.

Chairman TAUKE. And so has that had much impact, do you think, on the coverage of smaller businesses?

Ms. GRIFFIN. We certainly see it in a small group market. We see carriers that particularly come into the marketplace and draw off good risks, and they stay in the market for only a few years and then somehow choose to withdraw from that market, and as a long-term player in the market we've seen a certain impact of that on our business.

Chairman TAUKE. Mr. Crabtree, you gave a list in your testimony of possible regulatory activities, which I find interesting. I suspect it is somewhat unique, but I don't know. That's why I'm asking, is there consensus within the insurance industry that the kinds of reforms you suggest might be necessary?

Mr. CRABTREE. It would be erroneous to assume there is consensus within the insurance industry on anything.

Chairman TAUKE. That's like Congress, then.

Mr. CRABTREE. I'm not even sure if it's that. I'm here not speaking for the insurance industry. It would be impossible to do. It is so fragmentized, so many players. There are many who do and would agree with the sorts of things expressed in our list. We know that from conversations with them from time to time. To say that all would approve, no, probably not. There are those who want a completely unregulated environment.

Chairman TAUKE. You also indicated the desirability perhaps of requiring employers to provide health insurance for employees, and we've had some discussions about this earlier. And I think, as you know, I'm concerned about attaching the cost of health care to the cost of employing an individual, I'm not sure it's good social policy or economic policy. But in any event, I'm wondering if, as I read your testimony, you're saying that we would try to separate out the financially able firms from the financially unable firms. How would we do that? How could we determine which firms are financially able to provide health insurance for employees?

Mr. CRABTREE. Without making this a very formal and well thought out answer, the obvious place is to start whether or not they're paying taxes. If they don't pay Federal income taxes, then it may be necessary that that's a signal we give them some kind of help. It was suggested by someone earlier today to give them a bigger tax break than just the premium cost in order to provide an incentive to them to provide the care. That would be a pretty simple way to start.

Chairman TAUKE. Do you look at that mechanism for getting insurance to individuals going through the employer, do you look at that mechanism because you think that is the best mechanism available, or because it's one that we have traditionally used? Why

do you look at using that mechanism for getting insurance to individuals?

Mr. CRABTREE. The answer could almost be yes to both of your statements, but the reason is that it is the best delivery mechanism for those that can afford to pay, because of the flexibility that it offers to the public, they can choose whether they want a stripped down plan like Janet was talking about, or do they want a very fat program, and it also preserves the private marketplace in an environment where we can experiment, change the system, push the system in a much better fashion than the Federal Government can do or the State governments can do in a one size fits all kind of approach.

Chairman TAUKE. Of course I don't like the one size fits all government approach either. I want a different alternative, but we won't get into that yet.

Mr. Pomeroy, let's see, you indicated again, you've spent some time again talking about underwriting practices, and your group is specifically calling, as I understand it, for actuarial certification of rating strategies. I'm not sure exactly what that means, not being an insurance expert, and I guess I'd like to know specifically what you mean by that, and does this mean that current rates as we have them today are not actuarially certified.

Mr. POMEROY. Presently most State insurance departments do not require prior approval rate review of the insurance premium rates in the small group setting. The contemplated additional requirement would establish a standard of acceptable actuarial practices in developing the rating structures for the small group market, and require those to be on file, and should a State choose prior approval basis, which would then apply. So that isn't strictly rate review, but it's a major step in that direction. If I might defer to my colleague Assistant Commissioner Smith, I believe he might elaborate on that.

Mr. SMITH. Let me state a couple of points, if I might. One of the rules that we live under in insurance departments is that we determine that premiums are adequate, but the pressures of the public and the popular marketplace doesn't usually require us to pay much attention if they are low. As a consequence often prices are too low, hence the large increases may simply be the making up of some inadequate premiums at the onset. Because we don't look at these in advance, we haven't really done a good job as States generally in determining the adequacy of premiums that people have had to pay. And they're shocked when they learn of a rate increase of 50 percent or more, which really may be half of that was due to the fact that it was inadequate to start with. So what we're doing is we're saying to the insurers, and to other people that provide this coverage, you've got to tell us in actuarial terminology why you say your premium is adequate, why you say that it isn't excessive, and is nondiscriminatory. Those are our three general rules.

So asking the actuaries, the scientists to get involved with it as opposed to a business decision, it is, let's set the base rate on the basis of competition.

Chairman TAUKE. Which is the churning issue.

Mr. SMITH. That just leads to future problems with only those who have claims staying in that pool of risks that have been underwritten, the others opting out at the other lower price group.

Chairman TAUKE. When you were referring to the fact that there is no review of the premiums beforehand when insurance sales are made to small groups, is there review subsequent or afterward over a several year period, let's say, or are small group insurance premium costs simply not regulated much by State commissions.

Mr. SMITH. Essentially they are not regulated. Health insurance premiums are only regulated by some States on individual policies, but not on group insurance on the thesis that it's a business transaction between the employer buyer and the insurance company, and therefore not as subject to regulations as it would be if it were for an individual.

Chairman TAUKE. North Dakota, incidentally, is one of the States that I understand it has one of the oldest State risk pools in the Nation. And you heard our first witness discuss pooling arrangements as a possible mechanism for reducing cost in both the small group and individual market. I'm wondering if you have anything to relate to us about the advisability of moving in that direction based on your experience in North Dakota?

Mr. POMEROY. The general conclusion that can be drawn from North Dakota's experience is that the better the risk pool works as an accessible avenue for people otherwise unable to get insurance the more it will cost the State government in that you are making this available to people with cancer by virtue of health risk conditions access other coverage, we're going to have tremendous losses on those policies, those coverages. We begin our experiment with the risk pool concept by saying that the premiums will be actuarially sound, the premiums will cover the losses sustained by that group, and within only a few months the premiums required to cover the losses would have been completely unaffordable to virtually anyone. We've now capped those premiums at 135 percent of what an average individual premium would be and because of that premium cap there are tremendous losses. We pay out much more in claims than we do receive in premiums. Even at that it is still a device that's useful for people with health conditions. It does nothing to address the affordability issue, which is really the bigger of the uninsured problem, the near-poor or the poor, and so I think that risk pools have an important role as a safety net, but it is a safety net based on the ability to pay, and therefore I think it has kind of overtouted as an important component in answer to the uninsured problem.

Chairman TAUKE. Beth, you have suggested a number of questions at the end of your testimony, all of which are very interesting. Let me just ask if CRS has a perspective on one of them. "What practical financial incentives to insurers to accept high-risk applicants," are being proposed. Do we have any idea of the effect of these on insurer's behavior?

Ms. FUCHS. Well, I should never phrase questions that I don't know the answer to. There are many people within the Congress and I suspect throughout the country who are looking at ways in which to sort of encourage the insurance industry to bring in those higher risks. As so many people have said today, you need money,

and so what generally is being talked about are various forms of either State, local, or Federal subsidies to the insurance industry to essentially accept those high risks when you do it through the Tax Code or other devices. But then there's another question CRS now should suggest, of whether that is the legitimate response of Government, that is to put money to the insurance industry and essentially encourage them to do something which may already be their legitimate role.

Generally, I think the response to the question is that is there anything really very practical? Not that I have seen yet on the agenda, though we do describe some detail in our report, ways you could structure small incentives with that, again, some kind of subsidy or tax credit to get insurers to pick up perhaps the very highest risk. You have to think it's being talked about a whole lot in various kinds of government reinsurance pools, and my own personal judgment is that I haven't yet seen a proposal that looks very workable that doesn't mean a proposal doesn't exist.

Chairman TAUKE. Mr. Crabtree, one other thing came to mind, which I guess will be my final question, and that is in our discussions in the Commission we've had a number of interesting comments about the administrative costs in the insurance industry, and in your opening comments you quite eloquently, I thought, described what contributes to health insurance costs, the costs of health care and the administrative costs, and whatever profit a company might make. What are the administrative costs percentagewise for a typical insurance company in the United States at least as you would see it. What percentage of the premium of a typical health insurance premium in the United States is administrative cost?

Mr. CRABTREE. It's very difficult to describe a typical health insurance company in the United States. The better way, the comfortable way I can answer that is to say that it is not unreasonable to talk total cost, including Federal income tax, State premium taxes, marketing costs, administration costs, the whole thing, running into 10 to 15 percent of the entire operation. But if you were a General Motors size company your share of that may be 4 to 5 percent, whereas a small employer clearly, for some reasons that Beth suggested, much higher than that average.

Chairman TAUKE. I guess maybe I didn't make my question clear. I'm talking about the insurance company itself, is it, let's say, 80 percent of the cost of insurance for heath care payments and 20 percent for administrative costs?

Mr. CRABTREE. Using my rough and round numbers the claim costs would run from, get my math right here, from 80 to 85 percent.

Chairman TAUKE. OK.

Mr. CRABTREE. Well, those aren't the numbers, 85 to 90 is what—I said 10 to 15.

Chairman TAUKE. OK, I'm sorry.

Mr. CRABTREE. Ten to 15, so it would be 85 to 90, and then the administrative as a result is the remainder.

Chairman TAUKE. And that would include taxes as well as administrative costs and whatever and whatever profits a company might make?

Mr. CRABTREE. That 15 percent, yes, easy.

Chairman TAUKE. Any comments from the rest of you on that?

Ms. GRIFFIN. I would say generally that Blue Cross/Blue Shield organizations are not that high, but you would expect that because we are organized as a nonprofit corporation.

Mr. SMITH. I would point out that on smaller employers to whom we're addressing our thoughts today that percentage where claims may be lower and expenses may be higher, but by two causes, one is the compensation paid to sellers, commissions that are paid, which as a percent, are higher, but as a dollar amount are quite nominal. And the other is that the administrative expenses of acquisition and the like don't have as long a period to amortize because of the churning and the like, and they tend to be percentage points higher, even though the dollars are still quite small per individual unit of premium payment. So, in fact, most plans for small employers will portray a lower percentage of the total payments made as claims than they would from larger employers. But keep in mind larger employers pay additional costs such as the staffing of an employee benefit division, the risk manager, people that handle the claims for you when you're in your factory and in your office building and the like, which has to be consumed entirely by the insurance premium paid to the insurance company for small employers who don't have any of that support.

Chairman TAUKE. That's the point that you were trying to make, but I wasn't understanding. OK, thank you. Ed.

Mr. HOWARD. Very quickly, I know we're under some time pressures. But for Mr. Pomeroy, if affordability is the real problem, and if most State insurance regulators depend on market forces for small group policies that we've heard this morning at least have some gaps in their application, does that lead you to some belief that there ought to be tighter rate regulation or more frequent rate regulation in this market, or perhaps even as some have suggested national rate regulation?

Mr. POMEROY. We're strongly committed to the present regulatory framework for insurance, which would have State insurance departments performing whatever functions are deemed to be required and essential. I believe that the larger problems requiring our attention in this area involve underwriting and rating strategies rather than rate review. I don't believe that there is undue profit presently in the premiums charged to the small business, notwithstanding the absence in most cases for prior approval. I believe that it's an extremely competitive marketplace and that the ever-increasing costs of health care, which the premiums ultimately have to cover, have driven the levels of premiums to the very brink of affordability for the small employer, and that those very real market circumstances are an effective mechanism of regulating rates.

Mr. HOWARD. One real quick question of maybe Mr. Crabtree. You said that you can't insure a burning building. We've heard this morning some testimony of Mrs. Gansemer and Mr. Hunter who seem to be describing building where they had a fire a couple of years ago, but now the coals seem to have diminished and yet they still can't get any insurance. Is there a way to deal with that in the current structure?

Mr. CRABTREE. The system probably requires that we step through each one of those kind of situations to find out if it was the system that didn't work, whether it was ignorance that caused that to work, or just what the cause was. Maybe there is an answer that today is different. Somebody said the actuaries haven't caught up with it, that happens from time to time. I don't know that that was true in those particular situations, but in an enlightened step through those kind of examples it probably is what's required to make certain the system is not abusing when it shouldn't.

Chairman TAUKE. Well, ladies and gentlemen, thank you. And I wish to thank again all of our witnesses. I think it's been excellent testimony we've received this morning, speaks well for the great State of Iowa, and I thank people in our audience for their attention and appropriate applause and commentary as time went on.

[Whereupon, at 12:45 p.m., the hearing was adjourned.]

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